CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2357	**Date: November 23, 2011**
	Change Request 7636

SUBJECT: Intensive Behavioral Therapy for Cardiovascular Disease

I. SUMMARY OF CHANGES: Effective for claims with dates of service on and after November 8, 2011, CMS covers intensive behavioral therapy for cardiovascular disease, inclusive of one face-to-face risk reduction visit annually.

EFFECTIVE DATE: November 8, 2011
IMPLEMENTATION DATE: December 27, 2011 for non-shared system edits, April 2, 2012 for shared system edits, July 2, 2012, for CWF provider screens, HICR changes and MCS MCDST Changes

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	18/Table of Contents
N	18/160/Intensive Behavioral Therapy for Cardiovascular Disease (CVD)
N	18/160.1/Coding Requirements for IBT for CVD
N	18/160.2/Claims Processing Requirements for IBT for CVD
N	18/160.2.1/Correct Place of Services (POS) Codes for IBT for CVD on Professional Claims
N	18/160.2.2/Provider Specialty Edits for IBT for CVD on Professional Claims
N	18/160.3/Correct Types of Bill (TOB) for IBT for CVD on Institutional Claims
N	18/160.4/Frequency Edits for IBT for CVD Claims
N	18/160.5/Common Working File (CWF) Edits for IBT for CVD Claims

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachments - Business Requirements

Pub. 100-04	Transmittal: 2357	Date: November 23, 2011	Change Request: 7636

SUBJECT: Intensive Behavioral Therapy for Cardiovascular Disease

Effective Date: November 8, 2011

Implementation Date: December 27, 2011 for non-shared system edits
April 2, 2012, for shared system edits
July 2, 2012, for CWF provider screens, HICR changes and MCS MCDST Changes

I. GENERAL INFORMATION

A. Background: Pursuant to §1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (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.

The CMS reviewed the USPSTF recommendations and supporting evidence for intensive behavioral therapy for cardiovascular disease and determined that the criteria listed above was met, enabling the CMS to cover this preventive service. Effective November 8, 2011, Medicare will cover intensive behavioral therapy for cardiovascular disease if the service is provided by a primary care practitioner in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or nurse practitioner in the doctor's office.

B. Policy: Effective November 8, 2011, CMS covers intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit), which consists of the following three components:

- encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
- screening for high blood pressure in adults age 18 years and older; and,
- 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.

We note that only a small proportion (about 4%) of the Medicare population is under 45 years (men) or 55 years (women), therefore, the vast majority of beneficiaries should receive all three components. Intensive behavioral counseling to promote a healthy diet is broadly recommended to cover close to 100% of the population due to the prevalence of known risk factors.

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. 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.

The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the Five A's approach that has been adopted by the USPSTF to describe such services:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **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.
5. **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.

Note: A new HCPCS code, G0446, *Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes,* will be effective November 8, 2011, and will be included in the January 2012 update of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE).

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7636-04.1	Effective for claims with dates of service on and after November 8, 2011, contractors shall recognize HCPCS code G0446 when billed for Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD). G0446 will appear in the January 2012 MPFSDB update. The type of service (TOS) for G0446 is 1.	X		X	X		X			X	
7636-04.1.1	Contractors shall load G0446 to their HCPCS files with an effective date of November 8, 2011.	X		X	X						IOCE
7636-04.1.2	Effective for dates of service on and after November 8, 2011, through December 31, 2011, contractors shall apply contractor pricing to claims containing G0446 when billing for IBT for CVD.	X		X	X						
7636-04.2	Contractors shall pay claims for G0446 only when services are provided for the following place of service (POS):	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	11 - Physician's Office 22- Outpatient Hospital 49- Independent Clinic or, 71-State or local public health clinic										
7636-04.2.1	Contractors shall deny claims lines with G0446 with a POS code other than 11, 22, 49, or 71 with the following: 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." Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings." Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.	X			X						
7636-04.3	Contractors shall pay claims for G0446 only when services are submitted by the following provider specialty types found on the provider's enrollment record: 01= General Practice 08= Family Practice	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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										
7636-04.3.1	Contractors shall deny claim lines for G0446 performed by provider specialty types other than using 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." MSN 21.18: "This item or service is not covered when performed or ordered by this provider." Spanish Version: "Este servicio no está cubierto cuando es ordenado o rendido por este proveedor." Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.	X			X						
7636-04.4	Contractors shall allow institutional claims for Rural Health Clinics (RHCs), Type of Bill (TOB) 71X, and Federally Qualified Health Centers (FQHCs), TOB 77X, to submit additional revenue lines containing G0446.	X		X			X				
7636-04.5	Contractors shall pay for G0446 on institutional	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claims in RHCs (TOB 71X) and FQHCs (TOB 77X), based on the all-inclusive payment rate.										
7636-04.5.1	Contractors shall not pay G0446 separately with another encounter/visit on the same day on claims billed with TOBs 71X and 77X. NOTE: This does not apply for IPPE, claims containing modifier 59, and 77X claims containing DSMT & MNT services.	X		X			X				
7636-04.5.2	Contractors shall assign group code CO and reason code 97 to revenue lines with G0446 when an encounter/visit is present with the same line-item date of service. CARC 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 Services Payment Information REF), if present.	X		X			X				
7636-04.5.3	Contractors shall pay for G0446 on institutional claims in hospital outpatient departments (TOB 13X) based on OPPS and in critical access hospitals (TOB 85X) based on reasonable cost.	X		X			X				
7636-04.5.4	Contractors shall pay for G0446 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.	X		X			X				
7636-04.5.5	Contractors shall deny claims for G0446 when submitted on a TOB other than 13X, 71X ,77X or 85X 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."	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MSN 21.25: "This service was denied because Medicare only covers this service in certain settings." Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.										
7636-04.6	Effective for claims processed on or after April 2, 2012, contractors shall allow G0446 no more than once in a 12-month period. NOTE: 11 full months must elapse following the month in which the last IBT for CVD took place. CWF shall make this edit overridable.	X		X	X		X			X	
7636-04.6.1	Contractors shall deny claim lines for G0446 that exceed the frequency limit of once every 12 months using the following: 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." MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado." Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claim is received with a GA modifier indicating a signed 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 no signed ABN is on file.										
7636-04.6.2	When applying the frequency limitation to G0446, CWF shall allow both a claim for the professional service and a claim for a facility fee.									X	
7636-04.6.2.1	CWF shall identify the following institutional claims as facility fee claims for screening services: • TOB 13X, or, • TOB 85X when the revenue code is not 096X, 097X, or 098X.									X	
7636-04.6.2.2	CWF shall identify all other claims as professional service claims for IBT for CVD screening services.									X	
7636-04.7	Contractors shall hold institutional claims received before April 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting G0446.	X		X							
7636-04.7.1	Once the system changes described in this instruction are implemented, contractors shall release the held claims containing G0446, appending condition code 15.	X		X							
7636-04.8	CWF shall calculate a next eligible date for IBT for CVD for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules NOTE: The calculation for the next eligible date for IBT for CVD shall parallel claims processing.									X	NGD MBD
7636-04.8.1	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD MBD
7636-04.8.2	When there is no next eligible date the CWF provider query screens shall display an 8-position alpha code in the date field to indicate why there is no next eligible date.									X	NGD MBD
7636-04.8.3	Any change to beneficiary master data or claims									X	NGD

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	data that would result in a change to any next eligible date shall result in an update to the beneficiary's next eligible date.										MBD
7636-04.9	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCPCS G0446 counseling sessions in a format equivalent to the CWF HIMR screen.							X			
7636-04.9.1	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, the G0446 counseling sessions for IBT for CVD identified in 04.1.							X			
7636-04.10	Effective for claims with dates of service on or after November 8, 2011, contractors shall not apply deductible or coinsurance to claim lines containing G0446.	X		X			X				
7636-04.11	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.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7636-04.12	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Coverage: Jamie Hermansen, (410) 786-2064, jamie.hermansen@cms.hhs.gov, Patricia Brocato-Simons, (410) 786-0261, patricia.brocatosimons@cms.hhs.gov, Wanda Bell, (410) 786-7491, wanda.bell@cms.hhs.gov.

Practitioner Claims Processing: Cynthia Thomas, (410) 786-8169, cynthia.thomas2@cms.hhs.gov, Jocelyn Lissone, (410) 786-5116, jocelyn.lissone@cms.hhs.gov

Institutional Claims Processing: Wil Gehne, (410) 786-6148, wilfried.gehne@cms.hhs.gov, Elizabeth Carmody, (410) 786-5733, elizabeth.carmody@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*: The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents

(Rev.2357, 11-23-11)

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

(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

For services furnished on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers intensive behavioral therapy (IBT) for cardiovascular disease (CVD). See National Coverage Determinations (NCD) Manual (Pub. 100-03) §210.11 for complete coverage guidelines.

160.1 – Coding Requirements for IBT for CVD Furnished on or After November 8, 2011

(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

The following is the applicable Healthcare Procedural Coding System (HCPCS) code for IBT for CVD:

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

Contractors shall not apply deductibles or coinsurance to claim lines containing HCPCS code G0446.

160. 2 – Claims Processing Requirements for IBT for CVD Furnished on or After November 8, 2011

(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

160.2.1 – Correct Place of Service (POS) Codes for IBT for CVD on Professional Claims

(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

Contractors shall pay for IBT CVD, G0446 only when services are provided at the following POS:

11- Physician's Office
22-Outpatient Hospital
49- Independent Clinic
72-Rural Health Clinic

Claims not submitted with one of the POS codes above will be denied.

The following messages shall be used when Medicare contractors deny professional claims for incorrect POS:

*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."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.2.2 – Provider Specialty Edits for IBT for CVD on Professional Claims
(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

Contractors shall pay claims for HCPCS code G0446 only when services are submitted by the following provider specialty types found on the provider's enrollment record:

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

Contractors shall deny claim lines for HCPCS code G0446 performed by any other provider specialty type other than those listed above.

The following messages shall be used when Medicare contractors deny IBT for CVD claims billed with invalid provider specialty types:

*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."

MSN 21.18: "This item or service is not covered when performed or ordered by this provider."

Spanish version: "Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor."

Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.3 – Correct Types of Bill (TOB) for IBT for CVD on Institutional Claims
(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

Effective for claims with dates of service on and after November 8, 2011, the following types of bill (TOB) may be used for IBT for CVD: 13X, 71X, 77X, or 85X. All other TOB codes shall be denied.

The following messages shall be used when Medicare contractors deny claims for G0446 when submitted on a TOB other than those listed above:

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."

MSN 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.4– Frequency Edits for IBT for CVD Claims
(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

Contractors shall allow claims for G0446 no more than once in a 12-month period.

***NOTE**: 11 full months must elapse following the month in which the last G0446 IBT for CVD took place.*

Contractors shall deny claims IBT for CVD claims that exceed one (1) visit every 12 months.

Contractors shall allow one professional service and one facility fee claim for each visit.

The following messages shall be used when Medicare contractors deny IBT for CVD claims that exceed the frequency limit:

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."

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

Group Code PR (Patient Responsibility) 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 (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

160.5. – CWF Edits for IBT for CVD Claims
(Rev. 2357, Issued: 11-23-11, Effective: 11-08-11, Implementation: 12-27-11 non-shared system edits, 04-02-12 shared system edits, 07-02-12 CWF/HICR/MCS MCDST)

When applying frequency, CWF shall count 11 full months following the month of the last IBT for CVD, G0446 before allowing subsequent payment of another G0446 screening.

When applying frequency limitations to G0446, CWF shall allow both a claim for the professional service and a claim for the facility fee. CWF shall identify the following institutional claims as facility fee claims for screening services: TOB 13X, TOB85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims for screening services. NOTE: This does not apply to RHCs and FQHCs.