Using G Codes in the CHC 2013

FQHC... What Makes A CHC Unique

- Encounter Rate... Face-to-face with core provider
- Fixed Rate of Reimbursement vs. FFS
  - So why is coding important?
    - Appropriate capture of breadth & scope of service
    - Compliance
    - Commercial FFS maximization
    - Managed Medicaid with Encounter Rate secondary
    - Data collection for PPS change for Medicare in 2014 - data is being collected as of 1/1/11
- Cost Based Oversimplified... $100,000 to see 1,000 visits
- PPS (Medicaid) vs. Cost Based (Medicare)
  - PPS (Prospective Payment System)
    - Sets an FQHC specific baseline based on average cost per visit

Medicare vs. Medicaid Encounter Rate

<table>
<thead>
<tr>
<th>Medicare</th>
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<tbody>
<tr>
<td>UB-04 (ANSI 837I)</td>
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<tr>
<td>Medical: 521</td>
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<tr>
<td>Behavioral Health: 900</td>
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<tr>
<td>HCPCS detail (eff. 1/1/2011)</td>
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<tr>
<td>Three Encounter Types</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>a. 80% of Encounter Rate</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>a. Individual face-to-face</td>
</tr>
<tr>
<td>b. Encounter Rate Reduction</td>
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<tr>
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<tr>
<td>CMS 1500 (ANSI 837P)</td>
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<tr>
<td>T1015 (most of the time)</td>
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<tr>
<td>HCPCS detail</td>
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<tr>
<td>Four Encounter Types</td>
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<tr>
<td>Medical</td>
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<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>a. State licensure varies</td>
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<tr>
<td>b. Often allow group therapy</td>
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<tr>
<td>Dental</td>
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<tr>
<td>Diabetes Self Management Training</td>
</tr>
<tr>
<td>a. DSMT... a.k.a. CDE</td>
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<tr>
<td>b. State-to-state</td>
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Medicare Claim Formats

<table>
<thead>
<tr>
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<tr>
<td>CMS 1500 (ANSI 837P)</td>
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<tr>
<td>Four Typical Options</td>
</tr>
<tr>
<td>1. Office Based Diagnostic Lab</td>
</tr>
<tr>
<td>a. 81002: Urine Dip</td>
</tr>
<tr>
<td>b. X-Ray</td>
</tr>
<tr>
<td>78010-TC: Chest x-ray</td>
</tr>
<tr>
<td>93005: EKG (TC Only)</td>
</tr>
<tr>
<td>Machine Testing</td>
</tr>
<tr>
<td>a. 99221: Initial Hospital Care</td>
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<tr>
<td>b. Inpatient Surgery</td>
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FQHC – Core Provider

Medicare’s definition of a visit or billable encounter is: A face-to-face encounter in an outpatient setting between a patient and a FQHC Core Practitioner.

- Medical Doctor (MD, DO)
- Optometrist
- Podiatrist
- Chiropractor
- Physician’s Assistant (PA)
- Certified Midwife (CNM)
- Nurse Practitioner (NP)
- Clinical Psychologist (CP)
- Licensed Clinical Social Worker (LCSW)
- Certified Diabetic Educator

Note: Home Health Shortage areas will allow for RN to be core provider in a Home Health Capacity

Medicare Part A
Intermediary/FI

Medicare Part B
Carrier/MAC

Flat Cost-based Encounter Rate (Core Provider = threshold)

Unique Medicare Benefits
- Deductible... waived (Part B...yes)
- Preventive Visits (e.g., 99387, 99397) covered
- Expanded to include Annual Well Visit (AWV) G0438

Encounter Rate (Typically 80% of rate below)
- Rural: $110.78; Urban: $128.00
- Co-pay based on FFS charges
  - 99212 has charge of $45... co-pay is $9 NOT 20% of encounter rate
- No Co-pay for AWV and certain preventive services

Additional Encounter Rate Scenarios
- Nursing Facilities & Homebound patients
- Billing/Charge Entry… must know what is billable
  - Nurse Visits, INR, BP Checks, etc.

Technical component of diagnostic tests
- ECG = 93005;
- Chest X-ray = 71020 – TC
- Note: X-ray (reading) or KEG interpretation alone... no “encounter rate”

DME – crutches, wheelchairs

Ambulance Services

Prosthetics and Orthotic braces

Effective 1/1/2011 FQHC must report revenue code and HCPCS

FQHC... Medicare Encounter Rate

Nursing Facilities & Homebound patients

Encounter Rate Ineligible… CODE WHAT YOU DID
- Billing/Charge Entry… must know what is billable

Medicare Wrap Around
- Medicare Advantage “balance billing”
- Medicare As Secondary Payer (ASP) when using “incident to” billing option

NGS FQHC Provider Home for FQHC
http://www.ngsmedicare.com:ngs/portal/ngsmedicare/home?CONTRACTTYPE=Title%20XV
III%20Providers&LOB=Federally%20Qualified%20Health%20Center&utm_source=homepage&
utm_medium=home

CMS FQHC / RHC Manual (IOM 100–2 Chapter 13)
- Transmittal 166: New re-organization of Chapter 13

CMS FQHC Payment Calculations and Cost Reporting (IOM 104– Chapter 9)
www.cms.hhs.gov/manuals/downloads/clm104c09.pdf

2012 to FQHC Yearly Payment Limits
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHC/FQHCYearlyPaymentLimit.pdf
Levels of Coding

- Level I: CPT
- Level II: HCPCS
- Level III: Local Codes: No longer used

99213 99070 J3301

- Not to be confused with Diagnostic Coding
- ICD-9-CM soon to be ICD-10-CM

What are G Codes

- The G Codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT Codes.

- Always check CPT first, then if no appropriate code is found, consider using a G code.

Categories

- Procedures
- Quality Measures: Not available to the organizations who bill via flat encounter rate

Annual Wellness Visit

- 1. It is performed by qualified health professionals
- 2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

Services: The Annual Physical

- Annual Wellness Exam
- G0438 Includes a personalized plan of service; first visit
- G0439 Annual Wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit
- IPPE Exam
- G0402 Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare Part B enrollment
- G0403 Electrocardiogram, routine ECG with 12 leads, performed as a screening for the initial preventive physical examination with interpretation and report
- G0404 Electrocardiogram, routine ECG with 12 leads, tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
- G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

IPPE Exam

Annual Wellness Exam

- G0402 Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare Part B enrollment
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Annual Wellness Visit

- 1. It is performed by qualified health professionals
- 2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.
The IPPE includes the following components:

- Performance and interpretation of a screening electrocardiogram (must be billed on claim) (effective on and after January 1, 2009, this is no longer mandatory)
- Review of the individual’s medical and social history
- Review of the individual’s potential risk factors for depression, functional ability and level of safety with the goal of health promotion and disease detection
- Education, counseling, and referral with respect to screening and preventive services currently covered under Medicare Part B
- Measurement of height, weight, blood pressure, and visual acuity and, effective 1/9/2011, measurement of body mass index and other factors deemed appropriate based on the beneficiary’s medical and social history and current clinical standards
- End of life planning upon the individual’s consent (effective on and after January 1, 2009) End-of-life planning is verbal or written information provided to the beneficiary regarding: the beneficiary’s ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions; and whether or not the physician is willing to follow the beneficiary’s wishes as expressed in the advance directive

Cardiovascular Screening

- 80061 Lipid Panel
- 82465 Cholesterol, serum or whole blood, total
- 83718 Lipoprotein, direct measurement; high density cholesterol, HDL Cholesterol
- 84478 Triglycerides

The following screening diagnosis codes are valid when billing for the cardiovascular screening tests:

- V81.0 Special screening for ischemic heart disease
- V81.1 Special screening for hypertension
- V81.2 Special screening for other and unspecified cardiovascular conditions

Intensive Behavioral Therapy

- G0446 Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes.

Intensive Behavioral Therapy: Cardiovascular Screening

- Men aged 45 through 79 and women aged 55 through 79: Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks
- Adults aged 18 and older: Screening for high blood pressure
- Adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease: Intensive behavioral counseling to promote a healthy diet
- Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting
- Provided annually for covered beneficiaries

Colorectal Cancer Screening

- G0328 colorectal screening, fecal occult blood test, immunoassay 1–3 simultaneous determinations

Medicare patients ages 50 and over can only receive one FOBT per year, either 82270 (gFOBT, or guaiac based) or G0328 (fFOBT, or immunoassay-based), but not both.

Screening Flexible Sigmoidoscopy

- G0104: A screening flexible sigmoidoscopy is covered for beneficiaries age 50 and up when the test is performed by a physician or qualified non-physician practitioner.

The test is covered at a frequency of once every 4 years (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).
Diabetic Screening/Therapy

- Diabetic Screening
  - 82947 Assay, glucose, blood quant
  - 82950 Glucose test
  - 82951 Glucose tolerance test (gtt)
  - Use the TS modifier to indicate patient with pre-diabetes.

- Diabetic Self Management
  - G0108 DSMT, individual, per 30 minutes
  - G0109 DSMT, group (2 or more), per 30 minutes
  - Medical Nutritional Therapy
    - G0270
    - G0271

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Diabetic Screening and Self Management Training

- An individual with: one (1) of the following individual risk factors for diabetes is eligible for this new benefit:
  - Hypertension
  - Dyslipidemia
  - Obesity (with a body mass index greater than or equal to 30 kg/m2)
  - Previous identification of elevated impaired fasting glucose or glucose intolerance.

- Or an individual with any two (2) of the following risk factors for diabetes is also eligible for this new benefit:
  - Overweight (a body mass index greater than 25 but less than 30 kg/m2).
  - A family history of diabetes.
  - Age 65 years or older.

Coverage will be provided for one screening test every six months for individuals diagnosed with pre-diabetes (defined below), and one screening test within a 12-month period for individuals who were not diagnosed with pre-diabetes or who have never been tested.

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Self Management Training (DSMT)

- Up to 10 hours of initial training within a continuous 12-month period

- Subsequent years: Up to 2 hours of follow-up training each year after the initial year

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Medical Nutritional Therapy

- Coverage for MNT is only available for those beneficiaries diagnosed with diabetes, renal disease, or who have had a kidney transplant in the last three years, and a physician’s referral is required. Registered dietitians and nutrition professionals can receive direct Medicare reimbursement.

- General Conditions of Coverage
  - The following are the general conditions of coverage:
    - The treating physician must make a referral and indicate a diagnosis of diabetes, renal disease or who have received a kidney transplant within the last year.
    - The number of hours covered in an episode of care may not be exceeded (3 hours).
    - Services may be provided either on an individual or group basis.
    - For a beneficiary with a diagnosis of diabetes, Diabetes Self Management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT.

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Medical Nutritional Therapy

- The treating physician must make a referral for MNT services when the beneficiary has been diagnosed with diabetes or renal disease. The referring physician must maintain documentation in the beneficiary’s medical record.
  - 97802: Medical nutrition therapy: initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
    - NOTE: This CPT code is to be used for the initial visit. This code should be used only once a year, for the initial assessment of a new patient. All subsequent individual visits (including reassessments and interventions) are to be coded as 97803. All subsequent group visits are to be billed as 97804.
  - 97803: Reassessment and intervention, individual, face-to-face with patient, each 15 minutes.
    - NOTE: This code should be billed for all individual reassessments and all interventions after the initial patient’s medical condition that affects the nutritional status of the patient.
  - 97804: Group (2 or more individual(s)), each 30 minutes.
    - NOTE: Use this code for all group visits, initial and subsequent. This code can also be used when there is a change in the patient’s condition that affects the nutritional status of the patient and the patient is attending in a group.

- When there is a change in the condition of the beneficiary, these codes are billable:
  - G0270: Medical Nutrition Therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
  - G0271: Medical Nutrition Therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
**Hepatitis**

- Individuals with a family history of glaucoma, or
- End stage renal disease (ESRD) patients
- Hemophiliacs who receive Factor VIII or IX concentrates
- Clients of institutions for the mentally handicapped
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier
- Homosexual men
- Illicit injectable drug users
- Intermediate risk groups are:
  - (1) Individuals with diabetes mellitus,
  - (2) Individuals with a family history of glaucoma, or
  - African-American age 50 and over, when rendered by or under the direct supervision of an ophthalmologist or optometrist, who is legally authorized to perform the services under state law.
- Hispanic American age 65 and over, considered to be at high-risk.
- Screening for glaucoma is defined to include:
  - (1) A dilated eye examination with an intraocular pressure measurement and
  - (2) A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination

**Evaluation for Hepatitis B**

- Use the following list of procedure codes when billing mammography services:
  - 77051 Computer aided detection (computer algorithm analysis of digital image data for lesion detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List codes 77055, 77056, G0204 and G0206 separately in addition to the primary procedure performed)
  - 77052 Computer aided Detection (computer algorithm analysis of digital image data for lesion detection with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (List codes 77057 and G0202 separately in addition to the primary procedure performed)
  - 77053 Mammography, unilateral (Diagnostic)
  - 77054 Mammography, bilateral (Diagnostic)
  - 77057 Screening mammography, bilateral (two view film study of each breast)
  - G0202 Screening mammography, producing direct digital image, bilateral, all views
  - G0204 Diagnostic mammography, producing direct digital image, bilateral, all views
  - G0206 Diagnostic mammography, producing direct digital image, unilateral, all views

**Pneumococcal**

- **G0005:** Administration of Pneumococcal vaccine when no physician fee schedule service is performed on the same day
- Initial Medicare coverage for PPV is provided for:
  - Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and
  - Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin’s disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).
- Revaccination may be administered only to individuals at the highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine. Providers should inquire if the patient has had a prior vaccination.
The Bone Mass Measurement test can identify bone mass, detect bone loss, or determine bone quality. Testing devices include a bone densitometer, a bone sonometer, and computerized tomography. This procedure includes a physician’s interpretation of the test results. According to the consensus of the medical community, bone mass measurement studies are the most objective risk indicators for fractures and/or osteoporosis.

Bone Mass Measurement

- A qualified individual is an individual who meets the medical indications for at least one of the following categories:
  - A woman who, based on medical history and other findings, has been determined to be estrogen deficient as defined by her physician and is at clinical risk for osteoporosis.
  - An individual (male or female) with vertebral abnormalities, osteoporosis, osteopenia, or vertebral fracture demonstrated by x-ray.
  - An individual (male or female) with primary hyperparathyroidism.
  - An individual (male or female) being monitored to assess the response to or efficacy of an FDA-approved Osteoporosis drug therapy, or
  - An individual (male or female) receiving or expecting to receive glucocorticoid (steroid) therapy equivalent to 5.0 mg of prednisone, or greater per day for more than three months

Codes to Report for Bone Mass Measurements

- G0130: Single energy x-ray absorptiometry (SEXA) bone density, one ore more sites appendicular skeleton peripheral (i.e., radius, wrist, heel);
- 77078: Computed tomography bone mineral density study, one or more sites, axial skeleton (e.g., hips, pelvis, spine);
- 77079: Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist heel);
- 77080: Dual-energy x-ray absorptiometry (DEXA) bone density study, one ore more sites: axial skeleton (e.g., hips, pelvis, spine);
- 77081: Dual-energy x-ray absorptiometry (DEXA), bone density study, one or more sites appendicular skeleton, peripheral (i.e., radius, wrist, heel);
- 76977: Ultrasound bone mineral density measurement and interpretation, peripheral site(s), any method.

Ultrasound Screening for AAA

- G0389 (Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA))
- Patient Eligibility
  - Medicare patients are eligible to receive the screening AAA once per life time.
  - Medicare beneficiaries must also meet the following risk categories:
    - Has a family history of abdominal aortic aneurysm
    - Is a man age 65-75 who has smoked at least 100 cigarettes in his lifetime
    - Is a Medicare beneficiary who manifests other risk factors in a beneficiary category recommended by the United States Preventive Services Task Force regarding AAA as specified by the Secretary of Health and Human Services through the national coverage determination process
  - Medicare coverage criteria is required to be met for coverage, the Medicare coverage criteria is as follows:
    - The patient receives a referral for the Ultrasound as a result of an Initial Preventive Physical examination
    - The test is performed by a provider or supplier who is authorized to provide covered diagnostic services
    - The patient has not received a preventive ultrasound screening under the Medicare program

Intensive Therapy for Obesity

- G0447 - Face-to-face behavioral counseling for obesity, 15 minutes

Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²) 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.

HIV Screening

- HIV/AIDS
  - G0445 - 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
  - Sexually Transmitted diseases
    - 86613, 86632, 87110, 87270, 87320, 87490, 87491, 87810 - Chlamydia
    - 87590, 87591, 87850 - Gonorrhea
    - 87880 - Combined Chlamydia and gonorrhea testing
    - 86592, 86593, 86780 - Syphilis
    - 87340, 87541 - Hepatitis B (hepatitis B surface antigen)

HIV/STD

- High Intensity Counseling to prevent STD
  - G0445 - 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
  - Sexually Transmitted diseases
    - 86613, 86632, 87110, 87270, 87320, 87490, 87491, 87810 - Chlamydia
    - 87590, 87591, 87850 - Gonorrhea
    - 87880 - Combined Chlamydia and gonorrhea testing
    - 86592, 86593, 86780 - Syphilis
    - 87340, 87541 - Hepatitis B (hepatitis B surface antigen)
Medicare will cover the following HIV rapid screening tests. Copayment, Coinsurance and Deductible are waived.

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines. NOTE: 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.
- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: when the diagnosis is known, during the third trimester, and at labor if ordered by the woman’s clinician. NOTE: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

- V73.89 - special screening for other specified viral disease as primary
- V69.8 - other problems related to lifestyle as secondary
- V22.0 - for pregnant Medicare beneficiaries - supervision of normal first pregnancy as secondary
- V22.1 - for pregnant Medicare beneficiaries - supervision of other normal pregnancy as secondary
- V23.9 - for pregnant

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

**Patient Eligibility:**
- All Medicare beneficiaries are eligible for alcohol screening.
- Medicare beneficiaries who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence, are eligible for counseling if they are competent and alert at the time that counseling is provided and counseling is furnished by qualified primary care practitioners in a primary care setting.

**Deductible and Coinsurance:**
- Copayment/coinsurance/deductible waived.

**Billing Information:**
- G0412 – Annual alcohol misuse screening, 15 minutes (annually)
- G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (4 times per year)

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

**Patient Eligibility**
- Sexually active adolescents and adults at increased risk for STIs; HIBC consisting of individual, 20 to 30 minute, face-to-face counseling sessions, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting
- Increased risk for STIs is defined in Publication 100-03, Section 210.10

**Screening for Depression**

**All Beneficiaries:**
- Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up

**Billing Information:**
- G0444 – Annual depression screening, 15 minutes (annually)

**Tobacco Use**

Smoking and Tobacco Use Services
- G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
- G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

Report one of the following codes:
- 305.1 Non-dependent tobacco use disorder
- V15.82 history of tobacco use

**Tobacco: Symptomatic Beneficiaries**

- The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on Food and Drug Administration (FDA) approved information. Patients must be competent and alert at the time that services are provided.

To be eligible:
- Beneficiary must have a condition that is adversely affected by smoking or tobacco use
- Metabolism or dosing of a medication used to treat a condition has adversely been affected by smoking or tobacco use.
- Medicare will cover 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions in a 12-month period.
Effective for claims with dates of service on and after August 25, 2010, the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use services for outpatient and hospitalized Medicare beneficiaries:

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco–related disease
- Who are competent and alert at the time that counseling is provided
- Whose counseling is furnished by a qualified physician or other Medicare–recognized practitioner.

These individuals who do not have signs or symptoms of tobacco–related disease will be covered under Medicare Part B when the above conditions of coverage are met. Two cessation attempts per year are covered, each attempt includes a maximum of 4 intermediate or intensive sessions; up to 8 sessions in a 12–month period.

Medicare covers a screening pap test once every two years (at least 23 months must have passed following the month during which the beneficiary received her last covered pap test). Reimbursement can be made more frequently when:

- There is evidence on the basis of medical history or other findings that the patient is at high risk for cervical or vaginal cancer and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities of the prostate.
- Vaginal cancer or other abnormalities during any of the preceding 2 years; and at least 11 months have passed following the month that the last covered pap smear was performed.
- The patient is at high risk of developing cervical or vaginal cancer and at least 11 months have passed following the month that the last covered pap smear was performed.

The high risk factors for cervical and vaginal cancer are:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (5 or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative or any Pap tests within the previous 7 years
- DES (diethylstilbestrol)–exposed daughters of women who took DES during pregnancy.

The factors for women who are considered high-risk and are of childbearing age, who have had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding two years are:

Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative or any Pap smears within the previous 7 years

Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol)–exposed daughters of women who took DES during pregnancy.
- For asymptomatic low-risk patients use ICD–9–CM code
- V76.2 Special screening for malignant neoplasm, cervix
- V76.47 Special screening for malignant neoplasm, vagina
- V76.49 Special screening for malignant neoplasm, other site (use for a patient who does not have a uterus or cervix)

Screening Pap/Prostate

- Provides coverage of a screening pelvic examination for all female beneficiaries who are over 24 months or at least every 12 months. If the patient is at high risk for cervical or vaginal cancer, or she is of childbearing age and has had an abnormal Pap smear in the past 24 months. A screening pelvic examination should include at least seven of the following eleven elements:
  - Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
  - Digital rectal examination including sphincter tone, presence of hemmorhoids, and rectal masses.
  - Pelvic examination (with or without specimen collection for smears and cultures):
    - External genitalia (for example, general appearance, hair distribution, or lesions)
    - Urethra (for example, masses, tenderness, or straining)
    - Bladder (for example, fullness, masses, or tenderness)
    - Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
    - Cervix (for example, general appearance, lesions or discharge)
    - Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
    - Adnexa (parametria) (for example, masses, tenderness, organomegaly, or nodularity)
    - Anus and perineum

Screening Pelvis Exam

- Use code G0111 (cervical or vaginal cancer screening; pelvic and cervical breast examination) to report a pelvic and clinical breast examination.

Screening Digital Rectal Examination

- This test is a clinical examination of an individual’s prostate for nodules or other abnormalities of the prostate.
- Medicare pays for this examination when it is performed on a male Medicare beneficiary age 50 or older at a frequency of once every 12 months when performed by one of the following:
  - Physician (doctor of medicine or osteopathy)
  - Qualified physician assistant
  - Qualified nurse practitioner
  - Qualified nurse specialist
  - Qualified certified nurse midwife
Resources


Summary

- Documentation of the patient’s condition is key.
- If a review is conducted of services billed, the record must clearly indicate the requirements have been met for eligibility.
- Your billing managers should be able to support your decisions to bill for the services if the documentation exists.

Thanks for attending

- Questions are welcome.
- Consider joining our forum—it's free.
- Here you can ask questions and receive qualified responses.
- [www.gopmg.com](http://www.gopmg.com)