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## Helpful Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ABN</td>
<td>Advance Beneficiary Notice of Noncoverage</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CR</td>
<td>Change Request</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>IOM</td>
<td>Internet Only Manual</td>
</tr>
<tr>
<td>POS</td>
<td>Place of Service</td>
</tr>
<tr>
<td>USPSTF</td>
<td>United States Preventive Services Task Force</td>
</tr>
</tbody>
</table>
Agenda

• Overview of Screening and Preventive Services
• Resources & Helpful Information
Screening Services

• Services to detect an undiagnosed disease when early detection may prevent harm and where patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of disease
Diagnostic Services

• Services to manage a diagnosed disease or to evaluate symptoms, signs and abnormal laboratory or radiological findings in order to make a diagnosis

• Procedure that begins as screening, but uncovers significant pathology, requiring attention at that time, becomes a diagnostic procedure
  – Such as a polyp found during screening colonoscopy
USPSTF

• US Preventive Services Task Force (USPSTF) makes recommendations to guide medical practices, patients and payers in determining what preventive or screening services are recommended for individual patients.

• The Affordable Care Act (ACA), otherwise known as the health care reform bill, requires Medicare to cover services with an A or B rating at 100%, with no co-pay or deductible for fee-for-service Medicare beneficiaries.
Screening Services

- Abdominal Aortic Aneurysm (AAA)
- Advance Care Planning (ACP)
- Alcohol misuse
- Bone Mass Measurements (BMM)
- Cardiovascular
- Colorectal Cancer
- Depression
- Diabetes

- Glaucoma
- Hepatitis C
- Human Immunodeficiency Virus (HIV)
- Lung CA Screening
- Mammogram
- Pap Test
- Pelvic Examination
- Prostate Cancer
Screening for Abdominal Aortic Aneurysm (AAA)

- CPT 76706 replaces G0389 01/01/2017
  - Ultrasound exam for AAA screening
- Allowed once in lifetime
- Referral from MD, PA, NP or CNS
- Coinsurance and deductible waived

CR 9888
Screening to Reduce Alcohol Misuse

• G0442 – Once Annually
• G0443 – 4 per year Face to Face counseling - 15 minutes
• Counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting
• Coinsurance and deductible waived
SBIRT Services

- Identifies, reduces & prevents problematic substance use disorders with early intervention
  - Special documentation
- **G0396** (alcohol/other substance abuse assessment/intervention 15-30 mins.)
- **G0397** (additional 30 mins)

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Bone Mass Measurements

- Identifies bone loss, evaluates bone disease and determines bone quality
- Requires a referral/order
- Can only be billed once regardless of number of sites tested
- Coinsurance and deductible waived
Bone Mass Measurements

• Covered every 24 months for qualified individuals that fall into at least one category:
  – Vertebral abnormalities
  – Estrogen-deficient woman
  – Known primary hyperparathyroidism
  – Steroid use daily for more than 3 months
  – Being monitored to assess the response to, or efficacy of, an FDA-approved osteoporosis drug therapy

• More frequently if medically necessary
# Bone Mass Measurements

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Screening Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>76977</td>
<td>Ultrasound bone density measurement and interpretation</td>
</tr>
<tr>
<td>77078</td>
<td>CT axial skeleton</td>
</tr>
<tr>
<td>77080</td>
<td>DEXA axial skeleton</td>
</tr>
<tr>
<td>77081</td>
<td>DEXA appendicular skeleton</td>
</tr>
<tr>
<td>G0130</td>
<td>Single energy x-ray absorptiometry (SEXA)</td>
</tr>
</tbody>
</table>
Cardiovascular Screening

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Screening Blood Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
<td>Lipid Panel</td>
</tr>
<tr>
<td>82465</td>
<td>Cholesterol</td>
</tr>
<tr>
<td>83718</td>
<td>Lipoprotein</td>
</tr>
<tr>
<td>84478</td>
<td>Triglycerides</td>
</tr>
</tbody>
</table>

- Diagnosis codes: Z13.6
- Beneficiaries without signs or symptoms of disease
- Every 5 years
- Coinsurance and deductible waived
Colorectal Cancer

- Covered for individuals aged 50 and older
- 4 types of colorectal cancer screenings:
  - Fecal Occult Blood Test (FOBT)
  - Flexible sigmoidoscopy
  - Colonoscopy
  - Barium Enema
Colorectal Cancer

• Coding
  – Personal history:
    • Z85.038
    • Z85.048
  – Family history
    • Z80.0
    • Z83.71
  – Chronic digestive disease condition
    • D12.6
    • K50.00
    • K50.011 - K50.014
    • K50.018 - K50.019
    • K50.10
    • K50.111 - K50.114
    • K50.118 - K50.119
Fecal Occult Blood Test

• HCPCS/CPT Code 82270 or G0328
  – Covered once every 12 months
  – Deductible and coinsurance waived
• Provides 3 single cards, or single triple card for consecutive collection, to return for testing
• 82270- Clinical lab fee
• Dx Z12.76 or Z12.11
• Referral expansion – MD, PA, NP, CNS
Cologuard Multitarget Stool DNA (sDNA)

- CPT 81528- effective 1/1/16
  - Age 50-85
  - Asymptomatic, and
  - At average risk of developing colorectal cancer
  - Covered every 3 years
  - Deductible and coinsurance waived
- Diagnosis Z12.11 and Z12.12
- CR9115
Flexible Sigmoidoscopy

• Once every 10 years after first screening
  – High risk covered once every 48 months
• HCPCS code G0104 should be used
• Coinsurance and deductible waived
Colonoscopy

- Doctor of Medicine or Osteopathy must perform
- Colonoscopy (G0105 and G0121)
- Coinsurance and deductible waived
- Not covered Screening computed tomographic colonography (CTC),
Modifier 33

- **Modifier 33** is used to tell the payer “This is a service that should be processed without a patient due balance, because it was a preventive service with an A or B rating from the USPSTF”
Anesthesia and Colonoscopy

• Effective 1/1/2015
• 00810 separately payable (with codes G0105 and G0121)
• Append modifier 33 to the Anesthesia service
• Coinsurance and deductible waived
Modifier PT

• **Modifier PT**- Is used to indicate that a colorectal screening service converted to a diagnostic or therapeutic service.

• Billed with the appropriate colonoscopy codes (44380-44408, 45379 - 45392)

• Screening colonoscopies are covered by Medicare without a coinsurance or deductible
Coding for Polyps During a Screening Colonoscopy

- Physician billing change the code to one of these, 44380-44408, 45379 - 45392
- Bill the polypectomy or biopsy code)
  - Deductible and co-insurance applies
- Primary DX is screening code Z12.11 (Encounter for screening for malignant neoplasm of colon) or Z12.12,( encounter for screening for malignant neoplasm of rectum)
- Secondary DX might be D12.6 (Benign neoplasm of Colon).
- MLN-SE0746- reference
Screening VS Diagnostic
Item 21

• During a screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed

• Primary DX is screening code such as Z12.11 (Special screening for malignant neoplasms of Colon) or Z12.12,( encounter for screening for malignant neoplasm of rectum)

• Secondary DX might be D122 (Benign neoplasm of ascending colon)
Screening VS Diagnostic
Item 24

- Item 24D
  - Indicate the procedure(s) performed using the proper CPT code for the diagnostic service and the code if any other service done at that time. i.e. (biopsy or polypectomy)

- Item 24E
  - (Diagnosis Pointer) Enter only “B” (to link the procedure (polypectomy or biopsy) with the abnormal finding (polyp, etc.)

A Medicare beneficiary undergoing a screening colonoscopy (no symptoms and no abnormal findings prior to the procedure) will be responsible for the deductible if a polyp is identified and either biopsied or removed.
Ordering and Referring

• For ordering or referring for lab and/or pathology services associated with a diagnostic colonoscopy use the appropriate dx such as D122 to indicate it was not a screening service, it should be the primary dx

• Modifier PT or 33 should not be used for lab or pathology services.
Barium Enema

- Covered once every 48 months
  - High risk covered once every 24 months
- Covered as alternative to flexible sigmoidoscopy or colonoscopy; but not both
- G0106 – Barium enema; alternative to G0104
- G0120 – Barium enema; alternative to G0105
- Deductible waived
- Coinsurance applies
Diabetic Screening

- Coverage:
  - Non pre-diabetic - once every 12 months
  - Pre-diabetic - once every 6 months
    - TS modifier (follow-up service)
- Diagnosis Code - Z13.1
- CPT codes
  - 82947 - Glucose; quantitative, blood (except reagent strip)
  - 82950 - Glucose; post-glucose does (includes glucose)
  - 82951 - Glucose; tolerance test (GTT)
    - 3 specimens (includes glucose)
- Coinsurance and deductible waived

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Diabetes Risk Factors

• Risk Factors for Diabetes:
  – Hypertension
  – High Cholesterol
  – Obesity
  – Previous identification of elevated impaired fasting glucose or glucose intolerance

• With any two of following risk factors:
  – Overweight
  – Family history of diabetes
  – Age 65 or older
  – Gestational diabetes history or delivery of baby over 9 lbs.
Screening for Depression

- G0444 – Annual depression screening, 15 minutes
- Can be performed annually
- Can be performed in POS 11, 22, 19, 49 or 71
- Requires primary care settings with staff-assisted support
- Deductible/coinsurance are waived
More extensive procedure

• Some procedures can be performed at varying levels of complexity. The HCPCS/CPT codes corresponding to more extensive procedures always include the HCPCS/CPT codes corresponding to less complex procedures. HCPCS/CPT code G0438 (the column one HCPCS/CPT code) is a more extensive procedure that includes HCPCS/CPT code G0444 (the column two HCPCS/CPT code). Accordingly, only the more extensive procedure, HCPCS/CPT code G0438 (the column one HCPCS/CPT code) should be reported. HCPCS/CPT code _G0444_ (the column two HCPCS/CPT code) is bundled into HCPCS/CPT code G0438 (the column one HCPCS/CPT code).

• G0438 G0444 20120701 * 0 More extensive procedure
Glaucoma Screening

• Covered once every 12 months for high risk:
  – Diabetic
  – Family history
  – African-Americans age 50 and older
  – Hispanic Americans age 65 and older

• Includes:
  – Dilated eye exam with intraocular pressure measurement
  – Direct ophthalmoscopy exam or slit lamp biomicroscopic exam
Glaucoma Screening

- Procedure codes
  - G0117 – High risk screening by optometrist or ophthalmologist
  - G0118 – High risk screening under direct supervision of optometrist or ophthalmologist
- Diagnosis code
  - Z13.5
- Deductible and coinsurance apply
- Medicare does not pay for routine eye refractions
Hepatitis B

- CPT- 90739, 90740, 90743, 90744, 90746 and 90747
- Admin: G0010
- Diagnosis: Z23
- Coverage: immediate or high risk for contracting Hepatic B
- Copay/Coinsurance- Waived
- Deductible- Waived

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Hepatitis C Screening

- HCPCS - G0472
- Initial visit use Dx Z72.89
- Subsequent visits – Z72.89 and F19.20
- Deductible and coinsurance waived
- Non High Risk- once a lifetime
  - Any screening dx (ex: Z139-encounter for screening, unspecified)
- High Risk - Annually (full 11 months have past)

- CR 8871 and 9200
Hepatitis C Risk

High
- Current or past history of illicit injection drug use
- Blood transfusion prior to 1992
- Continue to test negative

Low
Persons born between 1945-1965
Human Immunodeficiency Virus (HIV) Screening

- Once annually for beneficiaries at increased risk for HIV infection
- 3 times per pregnancy for pregnant Medicare beneficiaries
  - Diagnosis of pregnancy
  - During 3rd trimester
  - At labor, if ordered by clinician
- Coinsurance and deductible waived
HIV Coding

- HCPCS G0432, G0433, G0435,
- Diagnosis Codes
  - Z11.4 and Z72.89 High Risk
  - Z11.4 Not High Risk
- Pregnant beneficiaries
  - Z11.4 Primary and
  - Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, O09.90-O09.93
HCPCS G0475

- G0475-(HIV antigen/antibody, combination assay, screening)
- Affective 4/13/15
- Annually
- Ages 15-65 without regard to perceived risk
- <15 and >65 who are at increased risk
- DX Z11.4 and Z72.51, Z72.89, Z72.52, or Z72.53
- POS 11 or 81
G0475

- High Risks
- Men who have sex with men;
- Men and women having unprotected vaginal or anal intercourse;
- Past or present injection drug users;
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or
- injection drug users;
- Persons who have acquired or request testing for other sexually transmitted
  infectious diseases;
- Persons with a history of blood transfusions between 1978 and 1985;
Mammogram Screening

• Covered annually for women 35 and older
  – Aged 35 through 39: one baseline
  – Aged 40 and older: annually
• Coinsurance and deductible waived

<table>
<thead>
<tr>
<th>Procedure Code</th>
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</thead>
<tbody>
<tr>
<td>77052</td>
<td>Computer-aided detection; screening mammography</td>
</tr>
<tr>
<td>77057</td>
<td>Screening mammography, bilateral</td>
</tr>
<tr>
<td>G0202</td>
<td>Screening mammography, digital</td>
</tr>
</tbody>
</table>

• Diagnosis Codes – Z12.31
Digital Breast Tomosynthesis

- Effective 1/1/2015
- Payment for 77063 (add on code) when billed with G0202, 2D imaging
- Bilateral code
- Dx Z12.31
- Coinsurance and deductible waived
PAP, Pelvic and Breast Exam

- Covered every 12 months for high risk
  - Abnormal pap within 36 months
- Covered every 24 months for low risk
- Coinsurance and deductible waived
- Screen pap and pelvic exam may be performed during same encounter
PAP, Pelvic and Breast Exam

• High risk:
  – Early onset of sexual activity
  – Multiple sexual partners
  – History of sexually transmitted disease
  – Fewer than 3 negative, or not having any, pap smears within the last 7 years
PAP, Pelvic and Breast Exam

• Screening pelvic exam
  – G0101
    • Cervical or vaginal cancer screening
    • Pelvic and clinical breast examination
  – Low risk office pap test codes
    • Q0091 – Screening pap smear; obtaining and conveyance to lab
      – May be billed on the same day as E/M
      – Modifier 25 should be appended to E/M
PAP, Pelvic and Breast Exam

- Clinical Laboratory Pap Smear codes
  - P3000 - Screening pap smear by technician
  - P3001 - Screening pap smear requiring physician interpretation
  - G0123 - G0148 – Screening cytopathology
- Diagnosis codes available
  - Z77.9, Z91.89, Z92.89, Z77.29, Z72.51-Z72.53 High Risk
  - Z12.4, Z12.72, Z12.79, Z12.89, Z01.411 and Z01.419 Low Risk
Screening for Cervical Cancer with HPV Testing - NCD 210.2.1

- HCPCS- G0476
- Effective 7/9/2015
- Allowed every 5 years
- Age 30-65
- POS 11 (Office), 81 (Independent Lab)
- DX Z11.51, Z01.411 or Z01.49

CR9434
Prostate Cancer Screening

• Covered every 12 months for men
  – Age 50 and older with physician’s order
  – At greater risk with family history

• Includes Digital Rectal Exam (DRE) and Prostate Specific Antigen (PSA)
Prostate Cancer Screening

• G0102 - DRE
  – Bundled unless only service that day
  – 20% co-insurance and deductible apply

• G0103 - PSA
  – Date of service (DOS) = date of collection
  – Provider collecting specimen must give DOS to lab
  – PSA – Co-insurance and deductible waived

• Both exams use same diagnosis code
  – Z12.5 – Special screening for malignant neoplasm's prostate
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

- Effective Date: 02/05/2015
- Implementation Date: 01/04/2016
- Coverage guides
  - Reasonable and necessary for prevention or early detection of illness or disability
  - Recommended with a grade of A or B by USPSTF
  - Appropriate for beneficiaries under Part A and Part B
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

- Eligibility requirements
  - Age 55 to 77 years
  - Asymptomatic
  - Tobacco smoking history of at least 30 packs per year
  - Current smoker or quit smoking within the last 15 years
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

- Eligibility Requirements
  - Written orders documented in medical records
    - Beneficiary’s date of birth
    - Actual pack smoked
    - Current smoking status or
    - Number of years since quitting
    - Statement that beneficiary is asymptomatic
    - NPI of ordering practitioner
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

- Before first screening
  - Counseling
  - Shared decision making visit
  - Written order for screening

- Subsequent screening
  - Written order
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

- **HCPCS Codes**
  - G0296  Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan
  - G0297  Low dose CT scan (LDCT) for lung cancer screening
  - DX Z87.891 (personal history of tobacco use/personal history of nicotine dependence),
- No deductible or coinsurance
- MM9246
New Diagnosis for LDTC

- Effective: July 5, 2016
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- F17.211 Nicotine dependence, cigarettes, in remission
- F17.213 Nitotine dependence, cigarettes, with withdrawal
- F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders
- F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
- MM9540

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Advance Care Planning (ACP)

- Voluntary – no official form
  - **99497** ~ Advance care planning includes explanation/discussion; face-to-face with patient and/or family; first 30 mins

  - **99498** ~ each additional 30 mins

- Not replacing living will/advance directive
- All specialties may provide
  - No frequency or POS limit

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Advance Care Planning (ACP)

- If performed “incident to”
  - Direct supervision must be met
- Not approved for group settings
- Same day as AWV (G0439)?
  - Append modifier 33 to ACP
  - Deductible/coinsurance waived when part of covered AWV
- CR 9271 – effective 01/01/16
ACP Example

• A 68-year-old male with heart failure and diabetes is on multiple medications. He is seen by his physician for the Evaluation and Management (E/M) of these two diseases, including adjusting medications as appropriate.

• In addition to discussing the patient’s short-term treatment options, the patient expresses his interest in discussing long-term treatment options. The doctor and patient talk over the possibility of a heart transplant if his congestive heart failure worsens, and ACP. That includes discussing the patient’s desire for care and treatment if he suffers a health event that adversely affects his decision-making abilities.
ACP Fact Sheet

Preventive Services
Preventive Services

- Diabetes Self-Management Training (DSMT)
- Medical Nutrition Therapy (MNT)
- Smoking Cessation
- Alcohol
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease
- Intensive Behavioral Therapy (IBT) for Obesity
- Sexually Transmitted Infections (STIs)
What is a Primary Care Setting?

- A primary care setting is defined as one in which there is a 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.
Diabetes Self-Management Training (DSMT)

• Physician must refer and certify plan of care with:
  – Number of sessions, frequency, duration
    • State whether individual or group DSMT service
  – Signed statement of need

• Upon diagnosis with diabetes, 10 initial hours of training are available

• Deductible and coinsurance apply
DSMT

- Nutrition portion of DSMT program must be billed using G0108 and G0109
  - G0108 – Individual session, 30 minutes
  - G0109 – Group session, 30 minutes
- For an hour session, indicate “2” in 24G or electronic equivalent
DSMT Helpful Hints

- DSMT provider must maintain documentation that includes:
  - Original order
  - Any instructions by ordering provider

- Any changes to training plan must be signed by ordering provider and kept in DSMT program records
DSMT

• Registered Dietitians may bill on behalf of DSMT program
  – Must have Medicare provider number
  – Cannot be sole provider of DSMT

• For Part A claims this is billed under the facility Information
DSMT

• Pharmacists
• Registered Nurses
• Certified Diabetic Educators

• These provider types can not bill independently to Medicare.
DSMT

• DSMT and MNT benefits can be provided to same beneficiary in same year but not same day
  – DSMT and MNT require separate referrals
• Medicare pays for up to 10 hours of initial DSMT within continuous 12-month period
  – Two hours of follow-up DSMT may be covered in subsequent years
Medical Nutrition Therapy (MNT)

• For purpose of disease management, covered services include:
  – Initial nutrition and lifestyle assessment
  – Nutrition counseling
  – Info regarding managing lifestyle factors that affect beneficiary’s diet
  – Follow-up sessions to monitor progress
MNT

• MNT is covered when beneficiary:
  – Diagnosed with diabetes, renal disease, or have received kidney transplant within last 3 years
  – Requires a physician referral
    • Non-physician practitioners cannot refer for MNT
  – Provided by registered dietitian or nutrition professional
• Three hours of one-on-one counseling covered in beneficiary’s 1\textsuperscript{st} year
  – Subsequent years – 2 hours of follow up
  – Unused hours from 1\textsuperscript{st} year can not carry over
  – Referrals need to be renewed annually
• Deductible and coinsurance waived
MNT Coding

- HCPCS

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
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<tbody>
<tr>
<td>97802</td>
<td>Initial assessment, 15 mins</td>
</tr>
<tr>
<td>97803</td>
<td>Re-assessment, 15 mins</td>
</tr>
<tr>
<td>97804</td>
<td>Group, 30 mins</td>
</tr>
<tr>
<td>G0270-G0271</td>
<td>Re-assessment and subsequent intervention</td>
</tr>
</tbody>
</table>
Smoking Cessation Counseling

• Tobacco is a leading cause of death
• Quitting can be difficult but can reduce risk of:
  – Abdominal Aortic Aneurysm
  – Cancer
  – Heart disease
  – Lung disease
  – Osteoporosis
  – Premature death
  – Stroke
Smoking Cessation Counseling

• Medicare covers smoking and tobacco-use counseling services for beneficiaries who meet one of the following coverage criteria:
  – Beneficiaries who use tobacco and have a disease or adverse health effect that has been found by U.S. Surgeon General to be linked to tobacco use
  – Beneficiaries who are taking therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA approved information
Smoking Cessation Counseling

• Medicare covers 2 attempts to quit per year
  – One attempt = up to 4 sessions
  – Second attempt = up to 4 additional sessions
• Nicotine gum and patches not covered
• Coinsurance/deductible waived
Smoking Cessation Coding

• HCPCS G0436/G0437 Deleted 9/30/16

<table>
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<tbody>
<tr>
<td>99406</td>
<td>Smoking cessation, 3-10 minutes</td>
</tr>
<tr>
<td>99407</td>
<td>Smoking cessation, 10+ minutes</td>
</tr>
</tbody>
</table>

• Diagnosis Codes
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease

- G0446 – Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes
- Allowed once in 12-month period
- Coinsurance and deductible do not apply
IBT Coding Cardiovascular

- HCPCS

<table>
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<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0446</td>
<td>Annual, face-to-face, 15 minutes</td>
</tr>
</tbody>
</table>
Intensive Behavioral Therapy (IBT) for Obesity

• Covered for Medicare beneficiaries:
  • With obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared);
  • Who are competent and alert at the time counseling is provided; and
  • Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
Intensive Behavioral Therapy (IBT) for Obesity

- G0447-Face-to-face behavioral counseling for obesity, 15 minutes
- Place of Service (POS): 11, 22, 49, 71
- MDs, CNS, PA, NP
- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12
  - If beneficiary meets 3kg (6.6 lbs) weight loss requirement during first 6 months

- Coinsurance and deductible waived
Intensive Behavioral Therapy (IBT) for Obesity

• G0473-Face-to-face behavioral counseling for obesity, group( 2-10 ) 20 minutes
• Place of Service (POS): 11, 22, 49, 71
• MDs, CNS, PA, NP
• Coinsurance and deductible waived
IBT Coding

• Diagnosis Codes
  – Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45
STIs and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

- Sexually active adolescents and adults at increased risk for STIs (defined in IOM Pub. 100-03, Sec. 210.10)
  - Screening for chlamydia, gonorrhea, syphilis, and hepatitis B
- HIBC – Up to two individual 20-30 minute face-to-face counseling sessions
  - If referred by primary care provider and provided by Medicare eligible primary care provider in primary care setting
STIs and HIBC Coding

- HCPCS
  - 86631, 86631, 87110, 87270, 87320, 87490, 87491, 87810 Chlamydia
  - 87590, 87591, 87850 Gonorrhoeae
  - 86592-3 Syphilis Test
  - 86780 Treponema pallidum (causes syphilis)
  - 87340, 87341 Hepatitis B
  - G0445 Semiannual HIBC to prevent STIs
STIs and HIBC Coding

- Diagnosis Codes
  - Z11.3, Z72.89, Z72.51, Z72.52, Z72.53, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z37.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, and O09.93
IOM References

• Medicare Internet Only Manual (IOM)
• 100-4 Medicare Claims Processing Manual
• Chapter 18 – Preventive and Screening Services
• Chapter 1, Part 4, Section 210. Prevention
• Internet Only Manual (IOM) 100-04
  – Chapter 18 Preventive Services
• Internet Only Manual (IOM) 100-02
  – Chapter 15, Section 300 – 300.5.1 (DSMT)
Resources

- Medicare Learning Network
- https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
  - Resources
  - ICD-10 Information
  - MAC Directory
  - Quick Reference Information: Preventive Services
  - FAQs
Preventive Services Listing

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Continuing Education Unit (CEU)

• Attend entire workshop to earn CEU(s)
• Take short polling survey
  – Pops up after closing out of webinar
• CEU emailed 3 days after presentation
  – Earn 1.5 CEUs today
  – No password/index number needed for AAPC
• PDF presentation emailed again with CEU
• Q/A posted after 30 business days
Thank you!