DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

REVISED products from the Medicare Learning Network® (MLN)--

- "Medicare Preventive Services Series: Part 2," Web-Based-Training Course

MLN Matters® Number: MM7610 Revised

Related Change Request (CR) #: 7610

Related CR Release Date: May 23, 2012

Effective Date: November 8, 2011

Related CR Transmittal #: R2476CP and R141NCD

Implementation Date: July 2, 2012 for full implementation

Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

Note: This article was revised on May 29, 2012, to reflect a revised CR7610 issued on May 23. In this article, the CR release date, transmittal number, and the Web address for accessing CR7610 were revised. All other information is the same.

Provider Types Affected

This MLN Matters® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for Medicare beneficiaries.

Provider Action Needed

Effective for dates of service on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover screening for Sexually Transmitted Infections (STIs) - specifically chlamydia, gonorrhea, syphilis, and hepatitis B - with the appropriate Food and Drug Administration (FDA) approved/cleared laboratory tests when ordered by the primary care provider. The tests must be used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare provider for these services.

In addition, Medicare will cover High Intensity Behavioral Counseling (HIBC) to prevent STIs. Ensure that your billing staffs are aware of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must be:

(1) Reasonable and necessary for the prevention or early detection of illness or disability;

(2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and

(3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for screening for STIs and HIBC to prevent STIs and determined that the criteria listed above were met, enabling CMS to cover these preventive services. Therefore, effective November 8, 2011, CMS will cover screening for the indicated STIs and HIBC to prevent STIs. The covered screening lab tests must be ordered by the primary care provider. The HIBC must be provided by primary care providers in primary care settings such as by the beneficiary's family practice physician, internal medicine physician, or nurse practitioner (NP) in the doctor's office.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0445 (high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes), has been created for use when reporting HIBC to prevent STIs, effective November 8, 2011. This code is included in the January 2012 Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE) updates.

This code may be paid on the same date of service as an annual wellness visit (AWV), evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.

The appropriate screening diagnosis code (ICD-9-CM V74.5 (screening bacterial – sexually transmitted) or V73.89 (screening, disease or disorder, viral, specified type NEC)), when used with the

screening lab tests identified by Change Request (CR) 7610, will indicate that the test is a screening test covered by Medicare.

Diagnosis code V69.8 (other problems related to life style) is used to indicate that the beneficiary is at high/increased risk for STIs. Providers should also use V69.8 for sexually active adolescents when billing G0445 counseling services.

Diagnosis codes V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy) are also to be used when appropriate.

For services provided on an annual basis, this is defined as a 12-month period.

Further Details

CMS will cover screening for Chlamydia (86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 (used for combined Chlamydia and gonorrhea testing), gonorrhea (87590, 87591, 87850, 87800 (used for combined Chlamydia and gonorrhea testing), syphilis (86592, 86593, 86780), and hepatitis B (hepatitis B surface antigen) 87340, 87341)) with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the CLIA regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. As per the requirements, the presence of V74.5 or V73.89 and V69.8, denoting STI screening and high-risk behavior, respectively, and/or V22.0, V22.1, or V23.9, denoting pregnancy as appropriate, must also be present on the claim for STI services along with one of the procedure codes above.

Screening for chlamydia and gonorrhea:

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test;
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test; and
- Women at increased risk for STIs annually.

Screening for syphilis:

- Pregnant women when the diagnosis of pregnancy is known and then repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening test; and
- Men and women at increased risk for STIs annually.

Screening for hepatitis B:

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known and then re-screening at the time of delivery for those with new or continuing risk factors.

Coverage for HIBC

CMS will also cover up to two, individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs (G0445) for all sexually active adolescents and for adults at increased risk for STIs (V69.8), if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements:

- Education;
- Skills training; and,
- Guidance on how to change sexual behavior.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners;
- Using barrier protection inconsistently;
- Having sex under the influence of alcohol or drugs;
- Having sex in exchange for money or drugs;
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea);
- Having an STI within the past year;
- IV drug use (hepatitis B only); and,
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age.

Community social factors such as high prevalence of STIs in the community populations should also be considered in determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending HIBC.

High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient's sexual history which is part of any complete medical history, typically part of an AWV or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

For the purposes of this NCD, a primary care setting is defined as the 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 (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

For the purposes of this NCD, a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (Sections 1833(u)(6), 1833(x)(2)(A)(i)(I) and 1833(x)(2)(A)(i)(II)), as follows:

- 1833(u) (6) Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in Section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.
- 1833(x)(2)(A)(i) (I) is a physician (as described in Section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in Section 1861(aa)(5)).

Billing Reminders

- Institutional providers should note that coverage requires services be performed in a primary care setting. Consequently, if STI services are billed on Types of Bill (TOB) other than 13X, 14X and 85X (when the revenue code on the 85X is not 096X, 097X, or 098X), OR, if G0445 is submitted on a TOB other than 13X, 71X, 77X, or 85X, payment for the services will be denied using the following:
  - Claim Adjustment Reason Code (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."
  - Remittance Advice Remark Code (RARC) N428 – "This service was denied because Medicare only covers this service in certain settings."
- When applying frequency limitations to HIBC services, contractors will allow both a claim for the professional service and a claim for the facility fee. Institutional claims may be identified as facility fee claims for screening services if they contain G0445, and TOB 13X or TOB 85X (when the revenue code is not 096X, 097X, or 098X). All other claims should be identified as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71X or 77X, or 85X when the revenue code is 096X, 097X, or 098X.
- Contractors will allow institutional claims, TOBs 71X and 77X, to submit additional revenue lines on claims with G0445. Also, HCPCS G0445 will not pay separately with another encounter/visit on the same day for TOBs 71X and 77X with the exception of: initial preventive physical claims, claims containing modifier 59, and 77X claims containing diabetes self-management training and

medical nutrition therapy services. If HCPCS G0445 is present on revenue lines along with an encounter/visit with the same line-item date of service, contractors will assign group code CO and reason code 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."

- G0445 on institutional claims in hospital outpatient departments (TOB 13X) are paid based on OPPS, in critical access hospitals (TOB 85X, not equal to 096X, 097X, or 098X) based on reasonable cost. HCPCS G0445 with revenue codes 096X, 097X, or 098X, when billed on TOB 85X Method II is paid based on 115 percent of the lesser of the MPFS amount or submitted charge.
- Medicare will enforce the frequency requirement for STI services, as mentioned above. Medicare will deny line items that exceed the coverage frequency requirements using the following:
  - CARC 119 – "Benefit maximum for this period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
- Medicare will deny line items on claims submitted for screening for STIs if the claim lacks the appropriate ICD-9-CM code as mentioned earlier. Such services will be denied payment using:
  - CARC 50 – "These are non-covered services because this is not deemed a "medical necessity" by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N386 – "This decision was based on a National Coverage Determination (NCD), An NCD provides a coverage determination as to whether a specific item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- The presence of ICD-9 code V74.5 or V73.89 identifies STI laboratory tests as screening lab tests payable under CR7610 rather than as diagnostic tests.
- Screening for STIs must be ordered by a primary care provider, and HIBC services, G0445, must be performed by a primary care provider in a primary care setting, with one of the following specialty codes:
  - 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

- STI screenings ordered by other than the above types of providers will be denied payment when submitted on professional claims using:
  - CARC 184 – "The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Medicare will deny line items for G0445 if performed by other than the above types of providers when submitted on professional claims using:
  - 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."
- Claims for G0445 must be for services performed in the following Places of Service (POS):
  - 11 – Physician Office;
  - 22 – Outpatient Hospital;
  - 49 – Independent Clinic; or
  - 71 – State or local public health clinic.
- Medicare will deny line items for G0445 if the POS code is other than 11, 22, 49, or 71, using the following:
  - 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."
  - RARC N428 – "Not covered when performed in this Place of Service."
- Upon full implementation in Medicare systems on July 2, 2012, providers may submit eligibility inquiries in order to identify the next eligible date that beneficiaries may receive these services.
- Until systems are implemented, contractors will hold institutional claims received before July 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting HCPCS G0445, or TOBs 13X, 14X, and 85X, when the revenue code is not 096X, 097X, or 098X, for STI services.
- Effective for dates of service on or after November 8, 2011, contractors will not apply deductible or coinsurance to claim lines containing HCPCS G0445, HIBC services.
- Contractors will load HCPCS G0445 to their HCPCS file with an effective date of November 8, 2011.

Additional Information

The official instruction, CR7610, was issued to your FI, carrier and A/B MAC regarding this change via two transmittals. The first updates the "Medicare Claims Processing Manual" and it is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2476CP.pdf on the CMS website. The second transmittal conveys the NCD and it is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141NCD.pdf on the same site.

If you have any questions, please contact your FI, carrier or A/B MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

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