CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2476	**Date: May 23, 2012**
	Change Request 7610

NOTE: Transmittal 2402, dated January 26, 2012, is being rescinded and replaced by Transmittal 2476, dated May 23, 2012 to remove "04.8.2" and replace with "04.8.3" in Business Requirements 7610-04.9 and 7610-04.10; and remove "deny claims for" and replace with "deny line items containing" in Business Requirements 7610-04.13.1 and 7610-04.15.2. All other information remains the same.

SUBJECT: Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10)

I. SUMMARY OF CHANGES: Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate FDA-approved lab tests used consistent with FDA-approved labeling and in compliance with CLIA regulations when ordered by a primary care provider and performed by an eligible Medicare provider for these services.

EFFECTIVE DATE: November 8, 2011
IMPLEMENTATION DATE: February 27, 2012 - Non-shared system edits
July 2, 2012 – Shared system edits, CWF Provider Screen, HICR, and MCSDT 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
R	18/Table of Contents
N	18/170/Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs
N	18/170.1/Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs
N	18/170.2/Diagnosis Code Reporting
N	18/170.3/Billing Requirements
N	18/170.4/Types of Bill (TOBs) and Revenue Codes
N	18/170.4.1/Payment Method
N	18/170.5/Specialty Codes and Place of Service (POS)

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.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2476	Date: May 23, 2012	Change Request: 7610

NOTE: Transmittal 2402, dated January 26, 2012, is being rescinded and replaced by Transmittal 2476, dated May 23, 2012 to remove "04.8.2" and replace with "04.8.3" in Business Requirements 7610-04.9 and 7610-04.10; and remove "deny claims for" and replace with "deny line items containing" in Business Requirements 7610-04.13.1 and 7610-04.15.2. All other information remains the same.

SUBJECT: Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10)

Effective Date: November 8, 2011

Implementation Date: February 27, 2012 - Non-shared system edits,
July 2, 2012 – Shared system edits, CWF Provider Screen, HICR, and MCSDT 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), (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 screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs and determined that the criteria listed above were met, enabling the CMS to cover these preventive services. Thus, effective November 8, 2011, CMS shall cover screening for the indicated STIs and HIBC to prevent STIs. The covered screening lab tests must be ordered by the primary care provider and 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 in the doctor's office.

A new 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, to be included in the January 2012 Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE) updates.

Code G0445 may be paid on the same date of service as an annual wellness visit, 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 appropriate screening diagnosis code (ICD-9 V74.5 – screening, bacterial – sexually transmitted, or V73.89 – screening, disease or disorder, viral, specified type NEC) with the screening lab tests identified in this CR will indicate that the test is a screening test and is therefore covered by Medicare as specified in the NCD.

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 to be used in addition to the above coding instructions when appropriate.

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

B. Policy: CMS will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care physician or practitioner, and performed by an eligible Medicare provider for these services:

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.
- 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.
- 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 rescreening at time of delivery for those with new or continuing risk factors.

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 for all sexually active adolescents, and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting. 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,
- 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)
- In addition for men – men having sex with men (MSM) and engaged in high risk sexual behavior, but no regard to age

In addition to individual risk factors, community social factors such as high prevalence of STIs in the community populations should 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 annual wellness visit 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, independent diagnostic testing facilities, skilled nursing facilities, 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 (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§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

§1833(x)(2)(A)(i) (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)).

NOTE: See Pub. 100-03, NCD Manual, section 210.10, and Pub. 100-04, CPM, section 18, chapter 170.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

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	

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	
	STI SCREENING										
7610-04.1	Effective for dates of service on and after November 8, 2011, contractors shall apply the instructions for processing screenings for STIs that are indicated in 04.1–04.12.2 below to the following procedure codes: • 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 • Hepatitis B: (hepatitis B surface antigen): 87340, 87341	X		X	X		X			X	
7610-04.1.1	Contractors shall only allow the following types of bill (TOBs) on claims for screening services listed in 04.1: • TOB 13X • TOB 14X • TOB 85X when the revenue code is not 096X, 097X, or 098X						X				
7610-04.1.2	Contractors shall deny claims for screening services listed in 04.1 containing ICD-9 diagnosis code V74.5 or V73.89 when submitted on a TOB other than 13X, 14X, and 85X (when the revenue code is not 096X, 097X, or 098X) using the following: CARC170: "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."	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	
	Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones." Group Code PR (Patient Responsibility) assigning financial responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7610-04.1.3	Until systems are implemented, contractors shall hold institutional claims received before July 2, 2012, with TOBs 13X, 14X, and 85X (when the revenue code is not 096X, 097X, or 098X) reporting any HCPCS code in BR 04.1 and ICD-9 diagnosis code V74.5 or V73.89.	X		X							
7610-04.1.3.1	Once the system changes described in this instruction are implemented, contractors shall release the held claims, appending condition code 15.	X		X							
7610-04.2	Contractors shall note that the presence of ICD-9 diagnosis code V74.5 or V73.89 identifies the lab tests indicated in BR 04.1 as screening lab tests payable under this CR rather than as diagnostic tests.	X		X	X		X	X		X	
7610-04.3	Contractors shall allow one (1) annual screening test (each) for chlamydia, gonorrhea, or syphilis in women at increased risk who are <u>not</u> pregnant when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V69.8 – Other problems related to lifestyle. **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.	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	
7610-04.3.1	CWF shall create an edit to allow no more than one (1) screening test per year for chlamydia, gonorrhea, or syphilis for female beneficiaries when the claim contains any of the codes for these tests contained in 04.1 along with ICD-9 diagnosis codes V74.5 and V69.8. **NOTE:** CWF shall allow this edit to be overridable.						X			X	
7610-04.4	Contractors shall allow one (1) annual screening for syphilis in men at increased risk when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V69.8 – Other problems related to lifestyle. **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.	X		X	X						
7610-04.4.1	CWF shall create an edit to allow no more than one (1) syphilis screening test per year for male beneficiaries when the claim contains any of the codes for syphilis contained in 04.1 along with ICD-9 diagnosis codes V74.5 and V69.8. **NOTE:** CWF shall allow this edit to be overridable.						X			X	
7610-04.5	Contractors shall allow up to two (2) screening tests per pregnancy for chlamydia in pregnant women who are at increased risk for STIs when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V69.8 – Other problems related to lifestyle; and, • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, • V23.9 – Supervision of unspecified high-risk pregnancy.	X		X	X						
7610-04.5.1	CWF shall create an edit to allow no more than						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	
	two (2) chlamydia screening tests per pregnancy beginning with the date of the 1st test containing any of the codes for chlamydia contained in 04.1, ICD-9 diagnosis codes V74.5, V69.8, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** CWF shall allow this edit to be overridable.										
7610-04.6	Contractors shall allow up to two (2) screening tests per pregnancy for gonorrhea in pregnant women who are at increased risk for STIs when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V69.8 – Other problems related to lifestyle; and, and, • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, • V23.9 – Supervision of unspecified high-risk pregnancy.	X		X	X						
7610-04.6.1	CWF shall create an edit to allow no more than two (2) gonorrhea screening tests per pregnancy beginning with the date of the 1st test containing any of the codes for gonorrhea contained in 04.1, ICD-9 diagnosis codes V74.5, V69.8, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** CWF shall allow this edit to be overridable.						X			X	
7610-04.7	Contractors shall allow one (1) screening test per pregnancy for syphilis in pregnant women when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, V23.9 – Supervision of unspecified high-risk pregnancy.	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	
7610-04.7.1	CWF shall create an edit to allow no more than one (1) syphilis screening test per pregnancy beginning with the date of the 1st test containing any of the codes for syphilis contained in 04.1, ICD-9 diagnosis code V74.5, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** CWF shall allow this edit to be overridable.						X			X	
7610-04.7.2	Contractors shall allow up to three (3) screening tests per pregnancy for syphilis in pregnant women if the beneficiary is at increased risk for STIs when the screening is billed with the following: • V74.5 – Screening, bacterial – sexually transmitted; and • V69.8 – Other problems related to lifestyle; and, • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, • V23.9 – Supervision of unspecified high-risk pregnancy.	X		X	X						
7610-04.7.3	CWF shall create an edit to allow no more than three (3) syphilis screening tests per pregnancy beginning with the date of the 1st test containing any of the codes for syphilis contained in 04.1, ICD-9 diagnosis code V74.5, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** The 2nd and 3rd tests must be billed with ICD-9 code V74.5, V69.8, and one of the diagnosis codes V22.0, V22.1, or V23.9. The initial test may be billed with or without V69.8. NOTE: CWF shall allow this edit to be overridable.						X			X	
7610-04.8	Contractors shall allow one (1) screening test per pregnancy for hepatitis B in pregnant women when the screening is billed with the following: • V73.89– Screening, disease or disorder, viral,	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	
	specified type NEC; and, • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, • V23.9 – Supervision of unspecified high-risk pregnancy.										
7610-04.8.1	CWF shall create an edit to allow no more than one (1) hepatitis B screening test per pregnancy beginning with the date of the 1st test containing any of the codes for hepatitis B contained in 04.1, ICD-9 code V73.89, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** CWF shall allow this edit to be overridable.						X			X	
7610-04.8.2	Contractors shall allow two (2) screening tests per pregnancy for hepatitis B in pregnant women who are at increased risk for STIs when the screening is billed with the following: • V73.89– Screening, disease or disorder, viral, specified type NEC; and • V69.8 – Other problems related to lifestyle; and, • V22.0 – Supervision of normal first pregnancy, or, • V22.1 – Supervision of other normal pregnancy, or, • V23.9 – Supervision of unspecified high-risk pregnancy.	X		X	X						
7610-04.8.3	CWF shall create an edit to allow no more than two (2) hepatitis B screening tests per pregnancy beginning with the date of the 1st test containing any of the codes for hepatitis B contained in 04.1, ICD-9 code V73.89, and one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** The 2nd test must be billed with V73.89, V69.8, and one of the diagnosis codes V22.0, V22.1, or V23.9. The initial test may be billed with or without V69.8.						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	
	NOTE: CWF shall allow this edit to be overridable.										
7610-04.9	Contractors shall deny line items submitted for chlamydia, gonorrhea, syphilis, and/or hepatitis B screening (as indicated by the presence of ICD-9 code V74.5 or V73.89) **that exceed the coverage frequency** limitations indicated in 04.3–04.8.3 with 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." MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service. Spanish Version: "La informacion proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo por este articulo o servicio." Group Code PR (Patient Responsibility) assigning financial responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X		X	X		X				
7610-04.10	Contractors shall deny line items submitted for chlamydia, gonorrhea, syphilis, and/or hepatitis B screening (as indicated by the presence of ICD-9 code V74.5 or V73.89) **that are billed without the appropriate ICD-9 codes** indicated in 04.3–04.8.3 with the following:	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	
	MSN 23.17: "Medicare won't cover these services because they are not considered medically necessary." Spanish Version: "Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas." 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 particular item or service is covered. A copy of this policy is available at 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." Group Code PR (Patient Responsibility) assigning financial responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7610-04.11	Contractors shall note that the appropriate ICD-10 codes are listed below. Contractors shall track these ICD-10 codes and ensure that the updated edits are turned on as part of the ICD-10 implementation 10/1/2013. NOTE: You will not receive a separate change request instructing you to implement the updated edits.	X		X	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	
	• Z113 – Encounter for screening for infections with a predominantly sexual mode of transmission • Z1159 – Encounter for screening for other viral diseases • ICD-10: Z7289 – Other problems related to lifestyle • ICD-10: Z3400 – Encounter for supervision of normal first pregnancy, unspecified trimester • ICD-10: Z3480 – Encounter for supervision of other normal pregnancy, unspecified trimester • ICD-10: O0990 – Supervision of high risk pregnancy, unspecified, unspecified trimester										
7610-04.12	Effective for dates of service on or after November 8, 2011, contractors shall allow screenings for chlamydia, gonorrhea, and syphilis when reported with ICD-9 code V74.5; and/or hepatitis B when reported with ICD-9 code V73.89, only when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes 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	X			X						
7610-04.12.1	MCS shall create an edit to deny claims with screening tests for chlamydia, gonorrhea, syphilis, and/or hepatitis B containing any of the codes in 04.1 and when billed with the diagnosis codes V73.89 or V74.5 when ordered by any provider specialty types other than those listed in 04.12.							X			
7610-04.12.2	Contractors shall deny claims for chlamydia, gonorrhea, syphilis, and/or hepatitis B screening when ordered by any provider specialty types	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	
	other than those listed in 04.12: 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." 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 responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
	HIBC COUNSELING										
7610-04.13	Effective for dates of service on and after November 8, 2011, contractors shall allow claims containing HCPCS G0445 for High Intensity Behavioral Counseling (HIBC) to prevent STIs when submitted with ICD-9 diagnosis code V69.8. **NOTE:** HCPCS G0445 will appear in the January 2012 MPFSDB update. The type of service (TOS) for HCPCS code G0445 is 1.	X		X	X		X	X			
7610-04.13.1	Contractors shall deny line items containing HCPCS G0445 that are submitted without V69.8 with the following:: MSN 23.17: "Medicare won't cover these services because they are not considered medically	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	
	necessary." Spanish Version: "Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas." 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 particular item or service is covered. A copy of this policy is available at 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." Group Code PR (Patient Responsibility) assigning financial responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7610-04.14	Effective for dates of service on and after November 8, 2011, through December 31, 2011, contractors shall apply contractor pricing to claims containing HCPCS G0445.	X			X						
7610-04.14.1	Contractors shall load G0445 to their HCPCS file with an effective date of November 8, 2011.	X		X	X						OCE
7610-04.15	For claims processed on or after July 2, 2012, CWF shall edit to allow only up to two (2) sessions in a 12-month period beginning with the									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	
	date of the first session for HCPCS G0445 when billed with ICD-9 V69.8 NOTE: 11 full months must elapse following the month in which the first session took place.										
7610-04.15.1	When applying frequency limitations to HCPCS code G0445, contractors shall allow both a claim for the professional service and a claim for a facility fee.									X	
7610-04.15.1.2	Contractors shall identify the following institutional claims as facility fee claims for screening services: • Procedure code in requirement 7610.04.15.1 and, • Type of bill 13X, or • Type of bill 85X when the revenue code is not 096X, 097X, or 098X.									X	
7610-04.15.1.3	Contractors shall identify all other claims as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71X, 77X, and 85X when the revenue code is 096X, 097X, or 098X).									X	
7610-04.15.2	For claims processed on or after July 2, 2012, upon receipt of the response from the CWF edit created in 04.15, contractors shall deny line items containing HCPCS G0445 that exceed the frequency limits and return the following messages: 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 responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7610-04.16	Contractors shall pay claims for HCPCS code G0445 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	X			X						
7610-04.16.1	Contractors shall deny claims for HCPCS G0445 performed by any other provider specialty types other than those listed in 04.16 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	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	
	cuando es ordenado o rendido por este proveedor." Group Code PR (Patient Responsibility) assigning financial responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
7610-04.17	Contractors shall allow institutional claims for Rural Health Clinics (RHCs) (TOB 71X) & Federally Qualified Health Centers (FQHCs) (TOB 77X) to submit additional revenue lines containing HCPCS G0445.	X		X			X				
7610-04.17.1	Contractors shall pay for HCPCS G0445 on institutional claims in RHCs (TOB 71X) and FQHCs (TOB 77X) based on the all-inclusive payment rate.	X		X			X				
7610-04.17.2	Contractors shall not pay HCPCS G0445 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, claims containing modifier 59, and 77x claims containing DSMT & MNT services.	X		X			X				
7610-04.17.2.1	Contractors shall assign group code CO and reason code 97 to revenue lines with HCPCS G0445 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				

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	
7610-04.18	Contractors shall pay for HCPCS G0445 on institutional claims in hospital outpatient departments (TOB 13X) based on OPPS and in critical access hospitals (TOB 85X, not equal to 096X, 097X, or 098X) based on reasonable cost.	X		X			X				
7610-04.18.1	Contractors shall pay for HCPCS G0445 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the MPFS amount or submitted charge. Deductible and coinsurance do not apply.	X		X			X				
7610-04.19	Contractors shall deny claims for HCPCS G0445 when submitted on a TOB other than 13X, 71X, 77X, or 85X using the following: CARC170: "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 responsibility 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). NOTE: For modifier GZ, use CARC 50 and MSN	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	
	8.81 per instructions in CR 7228/TR 2148.										
7610-04.20	Until systems are implemented, contractors shall hold institutional claims received before July 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting HCPCS G0445.	X		X							
7610-04.20.1	Once the system changes described in this instruction are implemented, contractors shall release the held claims, appending condition code 15.	X		X							
7610-04.21	Contractors shall pay claims for HCPCS G0445 only when services are provided for the following place of service (POS): 11- Physician's Office 22 - Outpatient Hospital 49 - Independent Clinic 71- State or local public health clinic	X			X						
7610-04.21.1	Contractors shall deny line items with G0445 and POS codes that are not listed in 04.21 with the following messages: 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." 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 responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).	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	
	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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.										
	ELIGIBILITY INQUIRIES – HIBC										
7610-04.22	Contractors shall calculate a next eligible date for HIBC G0445 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 preventive services next eligible date shall parallel claims processing.									X	NGD MBD
7610-04.22.1	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD MBD
7610-04.22.2	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
7610-04.22.3	Any change to beneficiary master data or claims data that would result in a change to any next eligible date shall result in an update to the beneficiary's next eligible date.									X	NGD MBD
7610-04.23	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCPCS G0445 in a format equivalent to the CWF HIMR screen.							X			
7610-04.23.1	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, HIBC G0445 identified in 04.13.							X			
	ADDITIONAL INSTRUCTIONS										
7610-04.24	Effective for dates of service on or after November 8, 2011, contractors shall not apply deductible or coinsurance to claim lines containing HCPCS G0445.	X		X	X		X			X	
7610-04.25	Contractors do not need to search their files for	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 that may have already been processed However; contractors may adjust claims that are brought to their attention.										

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	
7610-04.26	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 articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: 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):

Deirdre O'Connor, Coverage, 410-786-3263, deirdre.oconnor@cms.hhs.gov,
Patricia Brocato-Simons, Coverage, 410-786-0261, patricia.brocatosimons@cms.hhs.gov,
Wanda Belle, Coverage, wanda.belle@cms.hhs.gov, 410-786-7491,
Felicia Rowe, Supplier Claims Processing, 410-786-5655, felicia.rowe@cms.hhs.gov,
Cynthia Glover, Practitioner Claims Processing, 410-786-2589, cynthia.glover@cms.hhs.gov,
Bill Ruiz, Institutional Claims Processing, 410-786-9283, william.ruiz@cmes.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) 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.2476 Issued: 05-23-12)

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

(Rev.2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

170.1 - Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

Effective for claims with dates of service on and after November 8, 2011, the claims processing instructions for payment of screening tests for STI will apply to the following HCPCS codes:

- *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*
- *Hepatitis B: (hepatitis B surface antigen): 87340, 87341*

Effective for claims with dates of service on and after November 8, 2011, implemented with the January 2, 2012, IOCE, the following HCPCS code is to be billed for HIBC to prevent STIs:

- *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.*

170.2 – Diagnosis Code Reporting

(Rev. 2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

A claim that is submitted for screening chlamydia, gonorrhea, syphilis, and/or hepatitis B shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims for screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are <u>not</u> pregnant use the following diagnosis codes:

- *V74.5 – Screening, bacterial – sexually transmitted; and*
- *V69.8 - Other problems related to lifestyle as secondary (This diagnosis code is used to indicate high/increased risk for STIs).*

b. For claims for screening for syphilis in men at increased risk use the following diagnosis codes:

- *V74.5 – Screening, bacterial – sexually transmitted; and*
- *V69.8 - Other problems related to lifestyle as secondary.*

c. For claims for screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs use the following diagnosis codes:

- *V74.5 – Screening, bacterial – sexually transmitted; and*
- *V69.8 - Other problems related to lifestyle, and,*
- *V22.0 – Supervision of normal first pregnancy, or*
- *V22.1 – Supervision of other normal pregnancy, or,*
- *V23.9 – Supervision of unspecified high-risk pregnancy.*

d. For claims for screening for syphilis in pregnant women use the following diagnosis codes:

- *V74.5 – Screening, bacterial – sexually transmitted; and*
- *V22.0 – Supervision of normal first pregnancy, or,*
- *V22.1 – Supervision of other normal pregnancy, or,*
- *V23.9 – Supervision of unspecified high-risk pregnancy.*

e. For claims for screening for syphilis in pregnant women at increased risk for STIs use the following diagnosis codes:

- *V74.5 – Screening, bacterial – sexually transmitted; and*
- *V69.8 - Other problems related to lifestyle, and,*
- *V22.0 – Supervision of normal first pregnancy, or*
- *V22.1 – Supervision of other normal pregnancy, or,*
- *V23.9 – Supervision of unspecified high-risk pregnancy.*

f. For claims for screening for hepatitis B in pregnant women use the following diagnosis codes:

- *V73.89– Screening, disease or disorder, viral, specified type NEC; and*
- *V22.0 – Supervision of normal first pregnancy, or,*
- *V22.1 – Supervision of other normal pregnancy, or,*
- *V23.9 – Supervision of unspecified high-risk pregnancy.*

g. For claims for screening for hepatitis B in pregnant women at increased risk for STIs use the following diagnosis codes:

- *V73.89– Screening, disease or disorder, viral, specified type NEC; and*
- *V 69.8 - Other problems related to lifestyle, and,*
- *V22.0 – Supervision of normal first pregnancy, or,*
- *V22.1 – Supervision of other normal pregnancy, or,*
- *V23.9 – Supervision of unspecified high-risk pregnancy.*

ICD-10 Diagnosis Coding:

Contractors shall note the appropriate ICD-10 code(s) that are listed below for future implementation. Contractors shall track the ICD-10 codes and ensure that the updated edit is turned on as part of the ICD-10 implementation effective October 1, 2013.

ICD-10	*Description*
Z113	*Encounter for screening for infections with a*

	predominantly sexual mode of transmission
Z1159	*Encounter for screening for other viral diseases*
Z7289	*Other problems related to lifestyle*
Z3400	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z3480	*Encounter for supervision of other normal pregnancy, unspecified trimester*
O0990	*Supervision of high risk pregnancy, unspecified, unspecified trimester*

170.3 - Billing Requirements

(Rev.2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

Effective for dates of service November 8, 2011, and later, contractors shall recognize HCPCS code G0445 for HIBC. Medicare shall cover up to two occurrences of G0445 when billed for HIBC to prevent STIs. A claim that is submitted with HCPCS code G0445 for HIBC shall be submitted with ICD-9 diagnosis code V69.8.

Medicare contractors shall pay for screening for chlamydia, gonorrhea, and syphilis (As indicated by the presence of ICD-9 diagnosis code V74.5); and/or hepatitis B (as indicated by the presence of ICD-9 diagnosis code V73.89) as follows:

- *One annual occurrence of screening for chlamydia, gonorrhea, and syphilis (i.e., 1 per 12-month period) in women at increased risk who are <u>not</u> pregnant,*
- *One annual occurrence of screening for syphilis (i.e., 1 per 12-month period) in men at increased risk,*
- *Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening,*
- *One occurrence per pregnancy of screening for syphilis in pregnant women,*
- *Up to an additional two occurrences per pregnancy of screening for syphilis in pregnant women if the beneficiary is at continued increased risk for STIs,*
- *One occurrence per pregnancy of screening for hepatitis B in pregnant women, and,*
- *One additional occurrence per pregnancy of screening for hepatitis B in pregnant women who are at continued increased risk for STIs.*

170.4 - Types of Bill (TOBs) and Revenue Codes

(Rev.2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

The applicable types of bill (TOBs) for HIBC screening, HCPCS code G0445, are: 13X, 71X, 77X, and 85X.

On institutional claims, TOBs 71X and 77X, use revenue code 052X to ensure coinsurance and deductible are not applied.

Critical access hospitals (CAHs) electing the optional method of payment for outpatient services report this service under revenue codes 096X, 097X, or 098X.

170.4.1 - Payment Method

(Rev2476, Issued: 05-23-12, Effective: 11-08-11, Implementation: 02-27-12)

Payment for HIBC is based on the all-inclusive payment rate for rural health clinics (TOBs 71X) and federally qualified health centers (TOB 77X). Hospital outpatient departments (TOB 13X) are paid based on the outpatient prospective payment system and CAHs (TOB 85X) are paid based on reasonable cost. CAHs electing the optional method of payment for outpatient services are paid based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or submitted charge.

Effective for dates of service on and after November 8, 2011, deductible and coinsurance do not apply to claim lines with G0445.

HCPCS code G0445 may be paid on the same date of service as an annual wellness visit, 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.

For Medicare Part B physician and non-practitioner claims, payment for HIBC to prevent STIs is based on the MPFS amount for G0445.

170.5 – Specialty Codes and Place of Service (POS)

(Rev.2476, Issued: 05-12, Effective: 11-08-11, Implementation: 02-27-12)

Medicare provides coverage for screening for chlamydia, gonorrhea, syphilis, and/or hepatitis B and HIBC to prevent STIs only when ordered by a primary care practitioner (physician or non-physician) with any 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*

Medicare provides coverage for HIBC to prevent STIs only when provided by a primary care practitioner (physician or non-physician) with any of the specialty codes identified above.

Medicare provides coverage for HIBC to prevent STIs only when the POS billed is 11, 22, 49, or 71.