CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 671 **Date: SEPTEMBER 9, 2005**

CHANGE REQUEST 4045

SUBJECT: SUBJECT: Updated Manual Instructions for the Medicare Claims Processing Manual, Regarding Smoking and Tobacco-Use Cessation Counseling Services

I. SUMMARY OF CHANGES: This Change Request updates instructions located in Chapter 32 of the Medicare Claims Processing Manual.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2005
IMPLEMENTATION DATE: October 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	32/12/12.1/HCPCS and Diagnosis Coding
R	32/12/12.2/Carrier Billing Requirements
R	32/12/12.3/FI Billing Requirements
R	32/12/12.5/Medicare Summary Notices (MSNs)

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 671	Date: September 9, 2005	Change Request 4045

SUBJECT: Updated Manual Instructions for the Medicare Claims Processing Manual, Regarding Smoking and Tobacco-Use Cessation Counseling Services

I. GENERAL INFORMATION

A. Background: This Change Request updates instructions located in Chapter 32 of the Medicare Claims Processing Manual. Chapter 32 now adds the appropriate revenue code for Indian Health Service (IHS) providers to submit for Smoking and Tobacco-Use Cessation Counseling services, updates the method of payment for Critical Access Hospitals (CAHs), adds an inpatient payment methodology, and updates the recommended Medicare Summary Notice (MSN) 20.21 code to 21.21.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4045.1	Contractors shall update operational procedures, as necessary, to accommodate the following revisions to Chapter 32 of the Medicare Claims Processing Manual: - add the appropriate revenue code to be submitted by IHS providers; - update the method of payment for CAH hospitals; - add the inpatient payment methodology; and - update the recommended MSN code 20.21 to 21.21.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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12.1 - HCPCS and Diagnosis Coding

(Rev. 671, Issued: 09-09-05, Effective: 10-01-05, Implementation: 10-03-05)

The following HCPCS codes should be reported when billing for smoking and tobacco- use cessation counseling services:

G0375 - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

Short Descriptor: Smoke/Tobacco counseling 3-10

G0376 - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Short Descriptor: Smoke/Tobacco counseling greater than 10

NOTE: The above G codes will NOT be active in contractors' systems until July 5, 2005. Therefore, contractors shall advise providers to use unlisted code 99199 to bill for smoking and tobacco- use cessation counseling services during the interim period of March 22, 2005, through July 4, 2005, and received prior to July 5, 2005.

On July 5, 2005, contractors' systems will accept the new G codes for services performed on and after March 22, 2005.

Contractors shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code, such as HCPCS 99201– 99215, to report an E/M service with modifier 25 to indicate that the E/M service is a separately identifiable service from G0375 or G0376.

Contractors shall only pay for 8 Smoking and Tobacco-Use Cessation Counseling sessions in a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered cessation session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered cessation session was performed and count until 11 full months have elapsed.

Claims for smoking and tobacco use cessation counseling services shall be submitted with an appropriate diagnosis code. Diagnosis codes should reflect: the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

NOTE: This decision does not modify existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) which is already considered to be covered as part of each Evaluation and Management (E/M) visit and is not separately billable.

12.2 - Carrier Billing Requirements

(Rev. 671, Issued: 09-09-05, Effective: 10-01-05, Implementation: 10-03-05)

With the July 2005 quarterly update to the Medicare Physician Fee Schedule, carriers shall accept the above G codes for dates of service performed on and after March 22, 2005. The type of service (TOS) for each of the new codes is 9.

Carriers pay for counseling services billed with codes G0375 and G0376 based on the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, which means that charges to the beneficiary may be no more than 115 percent of the allowed amount.

Physicians or qualified non-physician practitioners shall bill the carrier for smoking and tobacco-use cessation counseling services on the Form CMS-1500 or an approved electronic format.

12.3 - FI Billing Requirements

(Rev. 671, Issued: 09-09-05, Effective: 10-01-05, Implementation: 10-03-05)

Effective for dates of service on and after July 5, 2005, FIs shall recognize the HCPCS codes in 12.1 for Smoking and Tobacco-Use Cessation Counseling services.

A. Claims for Smoking and Tobacco-Use Cessation Counseling Services should be submitted on Form CMS-1450 or its electronic equivalent.

The applicable bill types are 12X, 13X, 14X, 22X, 23X, 34X, 71X, 73X, 74X, 75X, 83X, and 85X.

Applicable revenue codes *are as follows:*

Provider Type	***Revenue Code***
Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)	*052X*
Indian Health Services (IHS)	*0510*
Critical Access Hospitals (CAHs) Method II	*096X, 097X, 098X*
All Other Providers	*0942*

NOTE: *When these services are provided by a Clinical Nurse Specialist in the RHC/FQHC setting, they are considered "incident to" and do not constitute a billable visit.*

Payment *for outpatient services* is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs)/Federally Qualified Health Centers (FQHCs)	All-inclusive rate (AIR) for the encounter
Indian Health Service (IHS)/Tribally owned or operated hospitals and hospital-based facilities	All-inclusive rate (AIR)
IHS/Tribally owned or operated non-hospital-based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated Critical Access Hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled Nursing Facilities (SNFs) **Note: Included in part A PPS for skilled patients.**	Medicare Physician Fee Schedule (MPFS)
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs)	Medicare Physician Fee Schedule (MPFS)
Critical Access Hospitals (CAHs)	Method I: Technical services are paid at 101% of reasonable cost. Method II: *technical services are paid at 101% of reasonable cost, and* Professional services are paid at 115% of the MMPFS Data Base
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

NOTE: *Inpatient claims submitted with Smoking and Tobacco-Use Cessation Counseling Services are processed under the current payment methodologies.*

12.5 - Medicare Summary Notices (MSNs)

(Rev. 671, Issued: 09-09-05, Effective: 10-01-05, Implementation: 10-03-05)

When denying claims for counseling services that were performed prior to the effective date of coverage, contractors shall use an appropriate MSN, such as, MSN 21.11, "This service was not covered by Medicare at the time you received it."

When denying claims for counseling services on the basis that the coverage criteria were not met, use an appropriate MSN, such as MSN *21.21*, "This service was denied because Medicare only covers this service under certain circumstances."

When denying claims for counseling services that have dates of service exceeding the maximum benefit allowed, use an appropriate MSN, such as MSN 16.25, "Medicare does not pay for this much equipment, or this many services or supplies."