

Internal Medicine Coding Alert

Preventive Care: Proper Coding of G0446 Key To Successful CVD Therapy Claim Submission

Hint: Check CCI when service is performed with other same day services.

If your internal medicine physician performs intensive behavioral therapy for cardiovascular disease prevention for a Medicare patient, you will need to know the HCPCS code that you will report for the service and also the components that need to be covered to allow you to report this code. In addition, you will need to know which other services you can or cannot report on the same calendar date of service.

Background: When your internist performs intensive behavioral therapy (IBT) for cardiovascular disease (CVD), you can report it with the HCPCS code, G0446 (Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes). The Medicare patient receiving this care must be competent and alert at the time the service is rendered. Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.

You report this code only once every year for a 15 minute face-to-face encounter with the patient. Code G0446 is submitted no more than once in a 12-month period. Eleven full months must elapse following the month in which the last screening took place.

Components of IBT

Intensive behavioral therapy for cardiovascular disease is also known as a CVD risk reduction visit. In general, the visit consists of three components:

- Encouraging aspirin use for primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
- Screening the patient for high blood pressure in adults age 18 years and older; and
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Documentation: If your physician performs intensive behavioral therapy for cardiovascular disease prevention, keep the "Five A" strategy in mind when completing your documentation to ensure that the following five factors are in your documentation:

- 1. Assess.** Ask the patient about his behavioral health risk(s) and any factors impacting his choice of behavior change goals and methods.
- 2. Advise.** Offer clear and specific personalized behavior change advice, with information about personal health harms and benefits.
- 3. Agree.** Work with the patient to choose appropriate treatment goals and methods that reflect the patient's interest in and willingness to change behavior.
- 4. Assist.** Help the patient achieve his goals via self-help and behavior change techniques like counseling, so he can get the skills, confidence, and social/environmental support required to follow the plan, supplemented with adjunctive medical treatments when appropriate.

5. Arrange. Schedule follow-up contacts to continue to support the patient and adjust the treatment plan when necessary, including referral to more intensive or specialized treatment.

Provider and POS requirements: Ensure that the chart reflects that a qualified provider performs the screening and counseling. The screening and the counseling should be performed by the beneficiary's primary care physician (which the Centers for Medicare & Medicaid Services (CMS) defines as general practice, family practice, internal medicine, obstetrics/gynecology, pediatric medicine, or geriatric medicine) or by the beneficiary's physician assistant, nurse practitioner, certified nurse midwife, or certified clinical nurse specialist.

Note that CMS also limits coverage and payment to certain sites of service. According to section 160 of chapter 18 of the Medicare Claims Processing Manual, CMS only pays for the service if it is provided in one of the following places of service:

- Physician's Office (Place of Service 11)
- Outpatient Hospital (Place of Service 22)
- Independent Clinic (Place of Service 49)
- State or local public health clinic (Place of Service 71)

CMS requires this service to be done in a primary care setting. CMS defines a primary care setting as 'one in which there is 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'.

Operationally, CMS determines that the service was provided in a primary care setting based on the provider specialty and the place of service. If either one is outside the accepted parameters described above, Medicare will not cover the service. Thus, for example, if an internal medicine physician provides this service in an emergency department or hospital inpatient setting, it is not covered, even though the service was provided by the patient's primary care physician.

Can G0446 be Reported with Same Day E/M or Other Preventive Services?

If your internist sees a patient for a scheduled Medicare annual wellness visit that you report with G0438 or G0439 and, in the same visit, he also performs the IBT for cardiovascular disease, you are allowed to report G0446 for this part of the encounter. You will need to provide separate documentation explaining the medical necessity of providing the IBT and also document the time interval spent face-to-face with the patient performing this service. There are no Correct Coding Initiative (CCI) bundling edits between the codes that you report for the Medicare annual wellness visit and G0446. So, you will not need to append any modifier to either of these codes.

On the other hand, if the physician is seeing the patient for a problem visit (that you will report with an appropriate problem-oriented E/M code) and, in the same visit, he also performs the IBT for cardiovascular disease, you will need to focus on CCI edits as you will face bundling if you are trying to report G0446 with any E/M code. The modifier indicator for the bundling between G0446 and E/M code is '1' which indicates that you can overcome the edit by using a modifier.

Since G0446 is the column 2 code in the edit bundle with E/M codes, you will need to append the modifier to G0446. The modifier that you will use with G0446 is 59 (Distinct procedural service). You will also need to provide adequate documentation to support both the services and substantiate breaking the edit.

Other Payers May Require Different Reporting

Because CMS created G0446 for Medicare payment purposes, other payers may not cover it in the same manner as CMS. "For instance, some payers may want you to report IBT for CVD as a preventive counseling service using one of the Current Procedural Terminology® (CPT®) codes in the range 99401-99404," a coding expert points out. The appropriate code will depend on the length of time spent with the patient.

Per the CPT® guidelines, these codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from E/M services, which may be reported separately when performed. As noted in CPT®, preventive medicine counseling and risk factor reduction interventions will vary with age and can address such issues as diet and exercise.

Because not all payers may recognize G0446, you are advised to check with non-Medicare payers before reporting to the code to them.

Resources: For more information on IBT for cardiovascular diseases, check the MLM Matters article at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7636.pdf>