DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

MLN Matters® Number: MM7633

Related Change Request (CR) #: 7633

Related CR Release Date: November 23, 2011

Effective Date: October 14, 2011

Related CR Transmittal #: November 23, 2011

Implementation Date: December 27, 2011, for local contractor system edits; April 2, 2012-for Medicare's shared system edits, July 2, 2012 for provider inquiry screens & HICR changes

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7633, which announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that

screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women. Make sure your billing staff is aware of these changes.

Background

Pursuant to Section1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if all of the following criteria are met. They 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 of the Medicare Program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,
- who are competent and alert at the time that counseling is provided; and,
- whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

NOTE: Two new G codes, G0442 (Annual Alcohol Misuse Screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for Alcohol Misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE). For claims with Dates of Service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13X, 71X, 77X, and 85X and release those claims beginning April 2, 2012.

For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 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

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11-Physician's Office
- 22-Outpatient Hospital
- 49-Independent Clinic
- 71-State or local public health clinic

Claims Processing/Payment Information

When claims for G0442 or G0443 are submitted with a Place of Service (POS) code that is not applicable, line-items on those claims will be denied using:

- Claim Adjustment Reason Code (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.
- Remittance Advice Remark Code (RARC) N428: "Not covered when performed in this place of service."
- Group Code CO (Contractual Obligation)

Medicare will deny claims for G0442 or G0443 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the dservice 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."
- Group Code CO.

Rural Health Clinics (RHCs) using type of bill (TOB) 71X and Federally Qualified Health Centers (FQHCs) using TOB 77X may submit additional revenue lines containing G0442 or G0443. Medicare will pay G0442 and G0443 in TOBs 71X and 77X based on the all-inclusive payment rate. However, Medicare will not pay G0442 or G0443 separately with another encounter/visit on the same day billed on TOBs 71X or 77X. This does not apply to claims for the Initial Preventive Physical Examination (IPPE), claims containing modifier 59, or to 77X claims containing Diabetes Self-Management Training or Medical Nutrition Therapy services. If G0442 or G0443 is billed when an encounter/visit with the same line item date of service, Medicare will assign:

- Group Code CO to the G0442/G0443 revenue lines; and
- RARC 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 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13X) will be paid based on the Outpatient Prospective Payment System. Those billed by Critical Access Hospitals (CAHs) on TOB 85X will be paid based on reasonable cost, except those G0442 or G0443 services billed with revenue codes 096X, 097X, or 098X by

Method II CAHs will receive 115% of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13X, 71X, 77X, or 85X will be denied using the following:

- CARC 5: "The procedure code/bitt type is inconsistent with the place of service." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M77: "Missing/incomplete/invalid place of service."
- Group Code CO.

Medicare will allow payment for both G0442 and G0443 on the same date (except in RHCs and FQHCs), but will not pay for more than one G0443 service on the same date. However, Medicare will allow both a claim for the professional service and, for TOB 13X and TOB 85X without a revenue code of 96X, 97X, or 98X, a claim for a facility fee. Claim lines for G0443 that exceed the limit of one on the same date of service will be denied using:

- CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
- RARC M86: "Service denied because payment already made for same/similar procedure within set time frame."
- Group Code CO.

Medicare will track payments for G0442 screening services and G0443 counseling services so as to not permit payment for G0442 more than once in a 12-month period, and for G0443 no more than 4 times in a 12-month period, beginning with the date of the G0442 service. Claim lines exceeding these limits will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group Code CO.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) along with HICR changes.

Additional Information

If you have questions, please contact your Medicare Carrier, MAC, or FI at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction, CR7633, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the "National Coverage Determinations Manual" at http://www.cms.gov/Transmittals/downloads/R138NCD.pdf on the CMS Website. The second transmittal at http://www.cms.gov/Transmittals/downloads/R2358CP.pdf modifies the "Medicare Claims Processing Manual".