CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2544	**Date: September 13, 2012**
	Change Request 7791

Transmittal 2488, dated June 21, 2012, is being rescinded and replaced by Transmittal 2544, dated September 13, 2012, to correct the Effective and Implementation dates from January 1, 2012 to October 1, 2012 in the Manual Instruction. All other information remains the same.

SUBJECT: Contractor and Common Working File (CWF) Additional Instructions Related to Change Request (CR) 7633 - Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

I. SUMMARY OF CHANGES: This change request serves to add additional instructions for contractors and CWF if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history. It also requires contractors to deny such claims with specific messages addressed in the business requirements.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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	32/Table of Contents
R	32/180.4/Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
R	32/180.5/Additional CWF and Contractor Requirements

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: 2544	Date: September 13, 2012	Change Request: 7791

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SUBJECT: Contractor and Common Working File (CWF) Additional Instructions Related to Change Request (CR) 7633 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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 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 Interventions 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.

In the Medicare population, Saitz (2005) defined risky use as >7 standard drinks per week or >3 drinks per occasion *for women and persons >65 years of age*, and >14 standard drinks per week or >4 drinks per occasion *for men ≤65 years of age.* Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 Clinician's Guide from the National Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

This CR serves to add additional instructions for contractors and CWF if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history. It also requires contractors to deny such claims with specific messages addressed in the business requirements below.

B. Policy: Effective for claims with dates of service October 14, 2011, and later, CMS covers 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.

See CR 7633, Transmittals 138 and 2358 dated November 23, 2011, for further instructions.

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	
7791.1	CWF shall create an edit to reject HCPCS code G0443 PROF when HCPCS code G0442 PROF has not been billed within a prior 12 month period.									X	
7791.1.1	Contractors and CWF shall deny claims for alcohol screening and behavioral counseling (G0443) PROF when no alcohol screening G0442 PROF is found in the beneficiary's history within 12 months.	X		X	X		X			X	
7791.1.2	Contractors shall use the following messages when denying these claims: Medicare Summary Notice (MSN) 16.26 – Medicare does not pay for services or items related to a procedure that has not been approved or billed. Claim Adjustment Reason Code (CARC) B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC) M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is	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	
	received with a modifier indicating a signed ABN is on file. Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.										
7791.2	CWF shall reject incoming claims when G0443, PROF is billed if four G0443, PROF services have been billed and posted to the BEHV auxiliary file within the 12 month period.						X			X	
7791.2.1	CWF shall continue to reject incoming claims with consistency error code '32#3' when HCPCS code G0442 PROF and HCPCS code G0443 PROF are billed on same day for TOB 71X, 77X, 85X with 096X, 097X and 098X.						X			X	
7791.3	If a claim with HCPCS code G0442 is cancelled, CWF shall do a look back for claims with HCPCS code G0443 and create an IUR (Information Unsolicited Response) along with a Trailer '24' back to the contractor to reject the G0443 claim(s) paid within the 12 month period of the G0442 claims.						X	X		X	
7791.4	Contractors and CWF shall use the last date of G0442, PROF for counting the 12-month period for G0443 PROF services.	X		X	X					X	
7791.4.1	Contractors and CWF shall all the same TOBs (13x, 71x, 77x, 85x, 85x with Rev Code 96, 97, 98) POS (11, 22, 49, 71) , no deductible/co-insurance, and institutional /professional processing for HCPCS code G0443 that was implemented for G0442 in CR7633.	X		X						X	
7791.5	CWF shall display the number of counseling sessions remaining for (G0443, PROF) on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD, MBD and HETS
7791.6	CWF shall display the remaining ~~TECH~~/PROF services counting DOWN from four (4) for HCPCS code 'G0443' on the MBD/NGD extract file.									X	NGD MBD
7791.6.1	CWF shall calculate a next eligible date for G0442 PROF and G0443, PROF for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status									X	NGD MBD

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	
	• Beneficiary claims history • Utilization rules **NOTE:** If G0442 is not paid, the beneficiary is not eligible for G0443.										
7791.6.2	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 not a next eligible date.									X	NGD MBD
7791.6.3	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
7791.7	CWF shall create a utility to remove previously posted G0442 TECH from the AUX file.									X	
7791.8	CWF shall remove G0442/G0443 TECH from editing, MBD, NGD, Provider Inquiry screens and all other applicable areas (i.e., HICR) previously done under CR 7633.									X	NGD MBD

II. 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	
7791.9	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	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	
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7633.04.4.2, 7633.04.4.2.1, 7633.04.4.2.2, 7866.01.4.2.3	CR 7633 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Yvette Cousar at (410) 786-2160 or Yvette.cousar@cms.hhs.gov for Practitioner Claims Processing Issues and Sarah Shirey-Losso at (410) 786-0187 or sarah.shirey-losso@cms.hhs.gov for Institutional Claims Processing Issues

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)*, include the following statement:

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.

180.4 - Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
(Rev 2544, Issued: 09-13-2012, Effective: 10-01-2012, Implementation: 10-01-2012)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for alcohol misuse screening and alcohol misuse behavioral counseling sessions:

- For RHC and FQHC claims that contain screening for alcohol misuse HCPCS code G0442 and alcohol misuse counseling HCPCS code G0443 with another encounter/visit with the same line item date of service, use group code CO and reason code:
  - Claim Adjustment Reason Code (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 Service Payment Information REF) if present

- Denying claims containing HCPCS code G0442 and HCPCS code G0443 submitted on a TOB other than 13X, 71X, 77X, and 85X:

  - Claim Adjustment Reason Code (CARC) 5 - The procedure code/bill 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

  - Remittance Advice Remark Code (RARC) M77 – Missing/incomplete/invalid place of service

  - Group Code PR (Patient Responsibility) assigning financial liability 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.

- Denying claims that contains more than one alcohol misuse behavioral counseling session G0443 on the same date of service:

  - Medicare Summary Notice (MSN) 15.6 – The information provided does not support the need for this many services or items within this period of time.

  - Claim Adjustment Reason Code (CARC) 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

  - Remittance Advice Remark Code (RARC) M86 – Service denied because payment already made for same/similar procedure within set time frame.

- Group Code PR (Patient Responsibility) assigning financial liability 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.

- Denying claims that are not submitted from the appropriate provider specialties:

  - Medicare Summary Notice (MSN) 21.18 – This item or service is not covered when performed or ordered by this provider.

  - Claim Adjustment Reason Code (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.

  - Remittance Advice Remark Code (RARC) N95 - This provider type/provider specialty may not bill this service.

  - Group Code PR (Patient Responsibility) assigning financial liability 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.

- Denying claims without the appropriate POS code:

  - Medicare Summary Notice (MSN) 21.25 – This service was denied because Medicare only covers this service in certain settings.

  - 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 PR (Patient Responsibility) assigning financial liability 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.

- Denying claims for alcohol misuse screening HCPCS code G0442 more than once in a 12-month period, and denying alcohol misuse counseling sessions HCPCS code G0443 more than four times in the same 12-month period:
  - Medicare Summary Notice (MSN) 20.5 – These services cannot be paid because your benefits are exhausted at this time.
  - Claim Adjustment Reason Code (CARC) 119 – Benefit maximum for this time period or occurrence has been reached.
  - Remittance Advice Remark Code (RARC) N362 – The number of Days or Units of service exceeds our acceptable maximum.
  - Group Code PR (Patient Responsibility) assigning financial liability 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.

- *Denying claims for alcohol misuse counseling session HCPCS code G0443 when there is no claim in history for the screening service HCPCS code G0442 in the prior 12 months:*
  - *Medicare Summary Notice (MSN) 16.26 – Medicare does not pay for services or items related to a procedure that has not been approved or billed.*
  - *Claim Adjustment Reason Code (CARC) B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*
  - *Remittance Advice Remark Code (RARC) M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.*
  - *Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed ABN is on file.*

- *Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.*

180.5 Additional CWF Requirements:

(Rev. 2544, Issued: 09-13-2012, Effective: 10-01-2012, Implementation:10-01-2012)

- When applying frequency, CWF shall count 11 full months following the month of the last alcohol misuse screening visit, G0442, before allowing subsequent payment of another G0442 screening.

- *CWF shall reject incoming claims when G0443 PROF is billed if four G0443 services have been billed and posted to the BEHV auxiliary file within the 12 month period.*

- *CWF shall continue to reject incoming claims with consistency error code '32#3' when HCPCS code G0442 PROF and HCPCS code G0443 PROF are billed on same day for TOB 71X, 77X, 85X with 096X, 097X and 098X.*

- *Contractors and CWF shall use the last date of G0442 PROF for counting the 12-month period for G0443 PROF services.*

  - *Contractors and CWF shall apply all the same TOBs (13x,71x, 77x and 85x with Rev. Code 96, 97 and 98) POS (11, 22, 49 and 71), no deductible/co-insurance and institutional/professional processing for G0443 that was implemented for G0442 in CR 7633.*

- *If a claim with G0442 is cancelled, CWF shall do a look back for claims with G0443 and create an IUR (Information Unsolicited Response) along with a Trailer '24' back to the contractor to reject the G0443 claim(s) paid within the 12 month period of the G0442 claims.*

- *CWF shall display the number of counseling sessions remaining for G0443 PROF on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).*

- *CWF shall display the remaining PROF services counting DOWN from four (4) for the HCPCS code 'G0443' on the MBD/NGD extract file.*

  - *CWF shall calculate a next eligible date for G0442 PROF and G0443 PROF for a given beneficiary.*

  - *The calculation shall include all applicable factors including beneficiary Part B entitlement status, beneficiary claims history and utilization rules.*

- *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 not a next eligible date.*

- *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.*

  NOTE: *If G0442 is not paid, the beneficiary is not eligible for G0443.*

  - *CWF shall create a utility to remove previously posted G0442 TECH for the AUX file.*

  - *CWF shall remove G0442/G0443 TECH from editing, MBD, NGD, Provider Inquiry screens and all other applicable areas (i.e., HICR) previously done under CR 7633.*

Frequency Requirements

When applying frequency, CWF shall count 11 full months following the month of the last alcohol misuse screening visit, G0442, before allowing subsequent payment of another G0442 screening. Additionally, CWF shall create an edit to allow alcohol misuse brief behavioral counseling, HCPCS G0443, no more than 4 times in a 12-month period. CWF shall also count four alcohol misuse counseling sessions HCPCS G0443 in the same 12-month period used for G0442 counting from the date the G0442 screening session was billed.

When applying frequency limitations to G0442 screening on the same date of service as G0443 counseling, CWF shall allow both a claim for the professional service and a claim for a facility fee. CWF shall identify the following institutional claims as facility fee claims for screening services: TOB 13X, TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims for screening services (professional claims, and institutional claims with TOB 71X, 77X, and 85X when the revenue code is 096X, 097X, or 098X). NOTE: This does not apply to RHCs and FQHCs.