CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12763	**Date: August 1, 2024**
	Change Request 13710

SUBJECT: Internet-Only Manual Update for Billing Code G0444 for Annual Depression Screening

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise manual language to include telehealth place of service codes for HCPCS code G0444 for Annual Depression Screening and to revise CWF edits.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

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	18/190/190.3 - Place of Service (POS)
R	18/190/190.5 - Professional Billing Requirements

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12763	Date: August 1, 2024	Change Request: 13710

SUBJECT: Internet-Only Manual Update for Billing Code G0444 for Annual Depression Screening

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise manual language to include telehealth place of service codes for HCPCS code G0444 for Annual Depression Screening and to revise CWF edits.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to revise manual language to include telehealth place of service codes for Healthcare Common Procedure Coding System (HCPCS) code G0444 for Annual Depression Screening and to revise Common Working File (CWF) edits.

B. Policy: There are no policy changes associated with this CR.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13710.1	Contractors shall be aware of and apply the changes to revised manual instructions found in Pub. 100-04, chapter 18.		X							
13710.2	CWF shall remove the POS criteria for updating the frequency limit for the annual screening depression.								X	

IV. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

190.3 - Place of Service (POS)
(Rev. 12763, Issued: 08-01-24; Effective: 01-01-25; Implementation: 01-06-25)

A/B MACs (B) shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):

02 - Telehealth Provided Other than in Patient's Home
10 - Telehealth Provided in Patient's Home
11 - Office
19 - Off Campus-Outpatient Hospital
22 - *On Campus-Outpatient Hospital*
49 - Independent Clinic
71 - State or Local Public Health Clinic

190.5 - Professional Billing Requirements
(Rev. 12763, Issued: 08-01-24; Effective: 01-01-25; Implementation: 01-06-25)

A/B MACs (B) shall use the following claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare Summary Notice (MSN) messages when denying payment for G0444 when reported more than once in a 12-month period.

o CARC 119 - "Benefit maximum for this time period or occurrence has been reached."

o RARC N362 - "The number of days or units of service exceeds our acceptable maximum."

o 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."

o 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.

o 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.

A/B MACs (B) shall use the following CARCs, RARCs, group codes, or MSNs messages when denying payment for G0444 and POS codes other than *those identified in section 190.3.*

o CARC *96 -* "*Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present*."

o RARC N428 - "Not covered when performed in this place of service."

o 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."

o 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.

o 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.