CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2358	**Date: November 23, 2011**
	Change Request 7633

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

I. SUMMARY OF CHANGES: Effective with dates of service on and after October 14, 2011, 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.

EFFECTIVE DATE: October 14, 2011
IMPLEMENTATION DATE: December 27, 2011 for non-systems changes
April 2, 2012 for shared system changes, July 2, 2012, for CWF provider screens, HICR changes, and MCS MCSDT changes

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
N	18/180/Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
N	18/180.1/Policy
N	18/180.2/Institutional Billing Requirements
N	18/180.3/ Professional Billing Requirements
N	18/180.4/Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes and Medicare Summary Notice Messages
N	18/180.5/Common Working File (CWF) 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: 2358	Date: November 23, 2011	Change Request: 7633

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

Effective Date: October 14, 2011

Implementation Date: December 27, 2011 for non-shared system edits
April 2, 2012, for shared system edits
July 2, 2012, for CWF provider screens, HICR changes, and MCS MCSDT changes

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).

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.

Each of the four behavioral counseling interventions must be consistent with the 5A's 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.

In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider. For the purposes of this NCD, a **"**primary care physician" and "primary care practitioner**"** will be defined consistent with existing sections of the Social Security Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)
(6) Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)(i)
(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5));

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 2012 update of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE)

II. BUSINESS REQUIREMENTS 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	

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	
7633-04.1	Effective for claims with dates of service on and after October 14, 2011, Medicare will allow coverage of annual alcohol misuse screening, 15 minutes, G0442, and brief face-to-face behavioral counseling for alcohol misuse, 15 minutes, G0443. Coverage is subject to the criteria found in Pub. 100-03, NCD Manual, section 210.8. Note: These codes will appear on the January 2012 Medicare Physician Fee Schedule update. The type of service (TOS) for G0442 and G0443 is 1.	X		X	X		X	X		X	
7633-04.1.1	Effective for claims processed for dates of service on and after October 14, 2011, through December 31, 2011, contractors shall apply contractor pricing to claims containing G0442 and/or G0443.	X		X	X						
7633-04.1.2	Contractors shall load G0442 and G0443 to their HCPCS file with an effective date of October 14, 2011.	X		X	X		X				IOCE
7633-04.2	Effective for claims with dates of service on and after October 14, 2011, contractors shall accept and pay claims for G0442 and G0443 only when services are submitted by the following provider specialty types found on the provider's enrollment record: 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	X			X						
7633-04.2.1	Contractors shall deny claims for G0442 and G0443 performed by provider specialty types other than those specified in 04.2 using the following: Medicare Summary Notice (MSN) 21.18 - This item or service is not covered when performed or ordered by this provider.	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	
	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.										
7633-04.3	Effective for claims with dates of service on and after October 14, 2011, contractors shall accept and pay for alcohol misuse screening and brief behavioral counseling claims G0442 or G0443 only when services are provided with the following place of service codes (POS): 11 - Physician's Office 22 - Outpatient Hospital 49 - Independent Clinic 71 - State or local public health clinic	X			X						
7633-04.3.1	Contractors shall deny line-items on claims for G0442 and G0443 without the appropriate POS code using the following: MSN 21.25 - This service was denied because Medicare only covers this service in certain settings. 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	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	
	Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 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.										
7633-04.4	Effective for claims processed on or after April 2, 2012, contractors shall accept and pay for alcohol misuse annual screening G0442 no more than once in a 12-month period.	X		X	X		X			X	
7633-04.4.1	CWF shall create an edit to allow G0442 alcohol misuse screening no more than once in a 12-month period. NOTE: CWF shall count 11 full months following the month of the last alcohol misuse screening visit when applying frequency editing. CWF shall make this edit overridable.						X			X	
7633.04.4.2	Effective for claims processed on or after April 2, 2012, contractors shall accept and pay for alcohol misuse brief behavioral counseling G0443 no more than 4 times in a 12-month period.	X		X	X		X			X	
7633-04.4.2.1	CWF shall create an edit to allow alcohol misuse brief behavioral counseling G0443 no more than 4 times in a 12-month period. NOTE: CWF shall make this edit overridable.						X			X	
7633-04.4.2.2	CWF shall count 4 counseling sessions of G0443 in a 12-month period counting from the G0442 screening session date.									X	
7633-04.4.2.3	Contractors shall line-item deny claims for G0442 billed more than once in a 12-month period and	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	
	G0443 billed more than 4 times in the same 12-month period as G0442 using the following: MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time. CARC 119 - Benefit maximum for this time period or occurrence has been reached. 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.										
7633-04.5	Contractors shall allow Rural Health Clinics (RHCs) type of bill (TOB) 71X & Federally Qualified Health Centers (FQHCs), TOB 77X, to submit additional revenue lines containing alcohol misuse screening G0442 and brief behavioral counseling G0443.	X		X			X				
7633-04.5.1	Contractors shall pay for alcohol misuse screening G0442 and brief behavioral counseling G0443 in RHC TOB 71X and FQHCs TOB 77X based on the all-inclusive payment rate. NOTE: Alcohol misuse screening and brief behavioral counseling are ***not*** separately payable with another encounter/visit on the same day. This does not apply for IPPE, claims containing modifier 59, and 77X claims containing DSMT & MNT services.	X		X			X				
7633-04.5.2	Contractors shall assign group code CO and reason code 97 to revenue lines with alcohol misuse screening G0442 and/or brief behavioral counseling G0443 when an encounter/visit is	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	
	present with the same line-item date of service. 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 Services Payment Information REF), if present.										
7633-04.5.3	Contractors shall pay for G0442 and G0443 on institutional claims in hospital outpatient departments TOB 13X based on OPPS and in critical access hospitals TOB 85X based on reasonable cost.	X		X			X				
7633-04.5.4	Contractors shall pay for G0442 and G0443 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the actual charge or the MPFS. Deductible and coinsurance do not apply.	X		X			X				
7633-04.5.5	Contractors shall deny any line item on a claim submitted with the alcohol misuse screening G0442 and/or brief behavioral counseling G0443 when the TOB is not 13X, 71X, 77X, or 85X with the following: 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. 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.	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	
7633-04.6	When applying frequency limitations to each screening in the requirements below, CWF shall allow both a claim for the professional service and a claim for a facility fee.									X	
7633-04.6.1	CF 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									X	
7633-04.6.2	CWF shall identify all other claims as professional service claims for screening services.									X	
7633-04.7	Contractors shall accept and pay for annual alcohol misuse screening G0442 and brief behavioral counseling for alcohol misuse G0443 claims on the same date of service. Note: This does not apply to RHCs and FQHCs.	X		X	X		X	X		X	
7633-04.7.1	Contractors shall line-item deny claims for more than one brief behavioral counseling for alcohol misuse G0443 on the same date of service using the following: MSN 15.6 - The information provided does not support the need for this many services or items within this period of time. 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 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	X		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	
	ABN is on file.										
7633-04.8	Effective for claims with dates of service on and after October 14, 2011, contractors shall not apply deductible and coinsurance for claim lines billed with annual alcohol misuse screening G0442 and brief behavioral counseling for alcohol misuse G0443.	X		X	X		X				
7633-04.9	Contractors shall calculate a next eligible date for alcohol screening G0442 and behavioral counseling G0443 for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules NOTE: The calculation for preventive services next eligible date shall parallel claims processing.						X			X	NGD MBD
7633-04.9.1	The next eligible date shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD MBD
7633-04.9.2	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 no 'next eligible date.'									X	NGD MBD
7633-04.9.3	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	
7633-04.9.4	The Multi-Carrier System Desktop Tool (MCSDT) shall display the G0442 and G0443 sessions in a format equivalent to the CWF HIMR screen.							X			
7633-04.9.5	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, the screening tests and counseling sessions for alcohol misuse identified in 04.0l.							X			
7633-04.10	Contractors shall hold institutional claims received before April 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting either G0442 or G0443.	X		X							
7633-04.10.1	Effective April 2, 2012, contractors shall release any held claims noted above, appending condition code 15.	X		X							
7633-04.11	Contractors need not search their files for claims	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	
	that may have already been processed. However, contractors may adjust claims brought to their attention.										

III. 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	
7633-04.12	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 supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s):

Coverage Policy: Maria Ciccanti, 410-786-3107, maria.ciccanti@cms.hhs.gov, Wanda Bell, 410-786-7491,wanda.belle@cms.hhs.gov, Pat Brocato-Simons, 410-786-0261, patricia.brocatosimons@cms.hhs.gov,

Part B Claims Processing: Yvette Cousar, 410-786-2160, Yvette.cousar@cms.hhs.gov, Chanelle Jones, 410-786-9668, chanelle.jones@cms.hhs.gov,

Part A Claims Processing: Sarah Shirey-Losso, 410-786-0187, sarah.shirey-losso@cms.hhs.gov, Shauntari Cheely, 410-786-1818, Shauntari.cheely1@cms.hhs.gov;

Post-implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) 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)*: 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.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev.2358, 11-23-11)

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

(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

The United States Preventive Services Task Force (USPSTF) defines alcohol misuse as risky, hazardous, or harmful drinking which places an individual at risk for future problems with alcohol consumption. In the general adult population, alcohol consumption becomes risky or hazardous when consuming:

- *Greater than 7 drinks per week or greater than 3drinks per occasion for women and persons greater than 65 years old.*
- *Greater than 14 drinks per week or greater than 4 drinks per occasion for men 65 years old and younger.*

180.1 - Policy

(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

Claims with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol misuse screening (HCPCS code G0442) consisting of 1 screening session, and for those that screen positive, up to 4 brief, face-to-face behavioral counseling sessions (HCPCS code G0443) per 12-month period for Medicare beneficiaries, including pregnant women.

Medicare beneficiaries that may be identified as having a need for behavioral counseling sessions include those:

- *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.*

Once a Medicare beneficiary has agreed to behavioral counseling sessions, the counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below.

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.*

180.2 – Institutional Billing Requirements
(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

For claims with dates of service on and after October 14, 2011, Medicare will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and brief, face-to-face behavioral counseling for alcohol misuse, 15 minutes, G0443 for:

- *Rural Health Clinics (RHCs) - type of bill (TOB) 71X only – based on the all-inclusive payment rate*
- *Federally Qualified Health Centers (FQHCs) - TOB 77X only – based on the all-inclusive payment rate*
- *Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System (OPPS)*
- *Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost*
- *CAH Method II – TOB 85X - based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.*

For RHCs and FQHCs the alcohol screening/counseling is not separately payable with another face-to-face encounter on the same day. This does not apply to the Initial Preventive Physical Examination (IPPE), unrelated services denoted with modifier 59, and 77X claims containing Diabetes Self Management Training (DSMT) and Medical Nutrition Therapy (MNT)services. DSMT and MNT apply to FQHCs only. However, the screening/counseling sessions alone when rendered as a face-to-face visit with a core practitioner do constitute an encounter and is paid based on the all-inclusive payment rate.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

Claims submitted with alcohol misuse screening and behavioral counseling HCPCS codes G0442 and G0443 on a TOB other than 13X, 71X, 77X, and 85X will be denied.

Effective October 14, 2011, deductible and co-insurance should not be applied for line items on claims billed for alcohol misuse screening G0442 and behavioral counseling for alcohol misuse G0443.

180.3 - Professional Billing Requirements
(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when services are submitted by the following provider specialties found on the provider's enrollment record:

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

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when submitted with one of the following place of service (POS) codes:

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

Any claims that are not submitted with one of the POS codes noted above will be denied.

The alcohol screening/counseling services are payable with another encounter/visit on the same day. This does not apply for IPPE.

180.4 - Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages
(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

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.*

- *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.*

- *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.*

- *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.*

- *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.*

180.5 CWF Requirements
(Rev. 2358, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-system changes, 04-02-12 shared system changes, 07-02-12 CWF/HICR/MCS MCSDT)

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 and make this edit overridable. 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. NOTE: This does not apply to RHCs and FQHCs.