CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2359	**Date: November 23, 2011**
	Change Request 7637

SUBJECT: Screening for Depression in Adults

I. SUMMARY OF CHANGES: Effective for claims with dates of service on and after October 14, 2011, contractors shall cover annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

EFFECTIVE DATE: October 14, 2011
IMPLEMENTATION DATE: December 27, 2011 for non-shared system edits, April 2, 2012 for shared systems edits; 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/Table of Contents
N	18/190/Screening for Depression in Adults
N	18/190.1/A/B Medicare Administrative Contractor (MAC) and Carrier Billing Requirements
N	18/190.2/Frequency
N	18/190.3/Place of Service (POS)
N	18/190.4/Common Working File (CWF) Edits
N	18/190.5/Professional Billing Requirements
N	18/190.6/Institutional Billing Requirements
N	18/190.7/CARCs, RARCs, Group Codes, and MSN Messages

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.*

Business Requirements

Pub. 100-04	Transmittal: 2359	Date: November 23, 2011	Change Request: 7637

SUBJECT: Screening for Depression in Adults

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: (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.

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services. Thus, effective October 14, 2011, CMS shall cover depression screening in adults. The covered services must be provided in primary care settings.

B. Policy: Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

A primary care setting is defined 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. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.

At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment.

More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.

NOTE: A new HCPCS G0444, *Annual Depression Screening, 15 minutes*, will be effective October 14, 2011, and will appear in the January 2012 update of the Medicare Physician Fee Schedule Database (MPFSDB) and the 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	
7637-04.1	Effective for claims with dates of service on and after October 14, 2011, contractors shall cover annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up subject to the criteria in Pub. 100-03, NCD Manual, section 210.9.	X		X	X						
7637-04.2	Effective for claims with dates of service on and after October 14, 2011, contractors shall recognize new HCPCS, G0444, annual depression screening, 15 minutes, as a covered service. **NOTE:** This code will appear on the January 2012 Medicare Physicians Fee Schedule update. The type of service (TOS) for HCPCS code G0444 is 1.	X		X	X		X			X	IOCE
7637-04.2.1	Effective for dates of service on and after October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444.	X		X	X			X			
7637-04.3	Effective for dates of service on and after October 14, 2011, through December 31, 2011, contractors shall apply contractor pricing to claims containing HCPCS G0444.	X		X	X						
7637-04.3.1	Contractors shall load G0444 to their HCPCS file with an effective date of October 14, 2011.	X		X	X						IOCE
7637-04.4	Effective for claims processed on or after April 2, 2012, Medicare contractors shall pay for annual depression screening, G0444, no more than once in a 12-month period. NOTE: 11 full months must elapse following the month in which the last annual depression screening took place.	X		X	X					X	
7637-04.4.1	CWF shall create a line-level edit to allow no more than one G0444 annual depression screening in a 12-month period beginning counting 11 full months from the month of the last screening.									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	
	NOTE: CWF shall allow this edit to be over-ridden.										
7637-04.4.2	When applying frequency limitations to HCPCS code G0444, CWF shall allow both a claim for the professional service and a claim for a facility fee.									X	
7637-04.4.3	CWF shall identify the following institutional claims as facility fee claims for screening services: • Type of bill 13X, or • Type of bill 85X when the revenue code is not 096X, 097X or 098X.									X	
7637-04.4.4	CWF shall identify all other claims as professional service claims for HIBC services.									X	
7637-04.4.5	Effective for claims processed on or after April 2, 2012, contractors shall deny line-items on claims with G0444 reported more than once in a 12-month period, contractors shall use the following: Claims 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." Medicare Summary Notice (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." 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		X			X	
7637-04.5	Contractors shall pay for annual depression	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	
	screening claims, G0444, only when services are provided at the followings places of service (POS): 11- Office 22 - Outpatient Hospital 49 - Independent Clinic 71 - State or Local Public Health Clinic										
7637-04.5.1	Contractors shall deny line items with G0444 and POS codes other than those listed in 04.5 with the following: 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." RARC N428 – "Not covered when performed in this place of service" 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." 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						
7637-04.6	Contractors shall allow institutional claims for Rural Health Clinics (RHCs) Type of Bill (TOB 71X) & Federally Qualified Health Centers (FQHCs) (TOB 77X) to submit additional revenue	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	
	lines containing HCPCS G0444.										
7637-04.6.1	Contractors shall pay for G0444 on institutional claims in RHCs (TOB 71X) and FQHCs (TOB 77X) based on the all-inclusive payment rate.	X		X			X				
7637-04.6.2	Contractors shall not pay G0444 separately with another encounter/visit on the same day on claims billed with TOBs 71X and 77X. NOTE: This does not apply for IPPE, claims containing modifier 59, and 77X claims containing DSMT & MNT services.	X		X			X				
7637-04.6.3	Contractors shall assign group code CO and reason code 97 to revenue lines with HCPCS G0444 when an encounter/visit is 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."	X		X			X				
7637-04.7	Contractors shall pay for HCPCS G0444 on institutional claims in hospital outpatient departments (TOB 13X) based on the Outpatient Prospective Payment System and in critical access hospitals (CAHs) (TOB 85X) based on reasonable cost.	X		X			X				
7637-04.7.1	Contractors shall pay for HCPCS G0444 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or the submitted charge. Deductible and coinsurance do not apply.	X		X			X				
7637-04.8	Contractors shall deny line-items on claims for HCPCS G0444 when submitted on a TOB other than 13X, 71X, 77X, or 85X using the following: CARC170: "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."	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	
	RARC N428 – "Not covered when performed in this place of service." 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." 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.										
7637-04.9	Contractors shall hold institutional claims received before April 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting HCPCS G0444.	X		X							
7637-04.9.1	Once the system changes described in this instruction are implemented, contractors shall release the held claims containing HCPCS G0444, appending condition code 15.	X		X							
7637-04.10	Contractors shall calculate a next eligible date for annual depression screening 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	NGD MBD
7637-04.10.1	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).						X			X	NGD MBD
7637-04.10.2	When there is no next eligible date, the CWF									X	NGD

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	
	provider query screens shall display an 8-position alpha code in the date field to indicate why there is not a next eligible date.										MBD
7637-04.10.3	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
7637-04.10.4	The Multi-Carrier System Desktop Tool (MCSDT) shall display the HCPCS G0444 sessions in a format equivalent to the CWF HIMR screen.							X			
7637-04.10.5	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, the depression screening sessions, G0444.							X			
7637-04.11	Contractors need not search their files for claims that may have already been processed. However, contractors may adjust claims that are brought to their attention.	X		X	X						

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	
7637-04.12	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	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	
	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: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Michelle Issa, Coverage and Analysis Group, michelle.issa@cms.hhs.gov 410-786-6656,Wanda Belle, Coverage, wanda.belle@cms.hhs.gov, 410-786-7491, Pat Brocato-Simons, Coverage, patricia.brocatosimons@cms.hhs.gov, 410-786-0261, Chanelle Jones, Practitioner Claims Processing, 410-786-9668, chanelle.jones@cms.hhs.gov, Bridgitte Davis, Practitioner Claims Processing, 410-786-4573, Bridgitte.davis@cms.hhs.gov, Cindy Pitts, Institutional Claims Processing, 410-786-2222, cindy.pitts@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. 2359,11-23-11)

190.0 - Screening for Depression in Adults (Effective October 14, 2011)

(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

A. Coverage Requirements

Effective October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual screening up to 15 minutes for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Screening for depression is non-covered when performed more than one time in a 12-month period. The Medicare coinsurance and Part B deductible are waived for this preventive service.

Additional information on this National Coverage Determination (NCD) for Screening for Depression in Adults can be found in Publication 100-3, NCD Manual, Section 210.9.

190.1 – A/B MAC and Carrier Billing Requirements

(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

Effective October 14, 2011, contractors shall recognize new HCPCS G0444, annual depression screening, 15 minutes.

190.2 - Frequency

(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

Medicare contractors shall pay for annual depression screening, G0444, no more than once in a 12-month period.

***NOTE:** 11 full months must elapse following the month in which the last annual depression screening took place.*

190.3 - Place of Service (POS)

(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

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

11 – Office
22 – Outpatient Hospital
49 – Independent Clinic
71 – State or Local Public Health Clinic

190.4 – Common Working File (CWF) Edits
(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

CWF shall count 11 full months from the month of the prior annual depression screening, G0444, before allowing subsequent payment.

190.5– Professional Billing Requirements
(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

Contractors 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.

- *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."*
- *MSN 20.5 – "These services cannot be paid because your benefits are exhausted as this time."*
  Spanish Version - "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."
- *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.*

Contractors shall use the following CARCs, RARCs, group codes, or MSNs messages when denying payment for G0444 and POS codes other than: 11-Office; 22-Outpatient Hospital; 49-Independent Clinic; and 71-State or Local Public Health Center.

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

190.6 – Institutional Billing Requirements
(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/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 screening depression in adults, HCPCS G0444 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 - Based on Outpatient Prospective Payment System (OPPS) TOB 13X – based on reasonable cost.*
- *Critical Access Hospitals (CAHs) TOB 85X – based on reasonable cost.*
- *CAH Method II with revenue codes 096x, 097x, or 098x only - based on 115% of the lesser of the actual charge or the MPFS.*

For RHCs and FQHCs, annual screening for depression in adults 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/or Medical Nutrition Therapy (MNT) services. DSMT and MNT apply to FQHC's only. However, annual screening depression by itself, when rendered as a face-to-face visit with a core practitioner, does 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 the annual screening depression HCPCS G0444 code on a TOB other than 13X, 71X, 77X, and 85X will be denied.

Effective for dates of service on and after October 14, 2011, deductible and coinsurance shall not be applied for claims billed for annual depression screening in adults with HCPCS G0444 at the line-level.

190.7- CARCs, RARCs, Group Codes, and MSN Messages
(Rev. 2359, Issued: 11-23-11, Effective: 10-14-11, Implementation: 12-27-11 non-shared system edits/04-02-12 shared system edits/07-02-12 CWF, HICR, MCS MCSDT)

Contractors shall use the appropriate CARC, RARC, group codes, or MSN messages when denying payment for annual depression screening in adults:

- *For RHCs and FQHCs when screening for depression, HCPCS code G0444, with another encounter/visit with the same line-item date of service, use group code CO and :*

- *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 G0444, submitted on a TOB other than 13X, 71X, 77X, and 85X:*

  - *MSN 21.25 – "This service was denied because Medicare only covers this service in certain settings."*
  - *CARC 170 - "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare 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.*

- *Denying claims containing HCPCS code G0444, depression screening in adults, more than once in a 12-month period:*

  - *MSN 20.5 – "These services cannot be paid because your benefits are exhausted at this time."*
  - *CARC 119 – "Benefit maximum for this 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.*