

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services



**News Flash** – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare's program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found [here](#). Alternatively, these FAQ items can be found by visiting <http://questions.CMS.hhs.gov> and searching for "PCIP" or "Primary Care Incentive Payment."

MLN Matters® Number: MM7637 **Revised**

Related Change Request (CR) #: 7637

Related CR Release Date: March 23, 2012

Effective Date: October 14, 2011

Related CR Transmittal #: R139NCD and R2431CP

Implementation Date: April 2, 2012

### Screening for Depression in Adults

**Note:** This article was revised on March 27, 2012, to reflect the revised CR7637 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the web address for accessing CR7637 have been revised. Also, the article reflects the addition of Claim Adjustment Reason Code (CARC) 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same.

### Provider Types Affected

Physicians, non-physician practitioners, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

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## Provider Action Needed

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### STOP – Impact to You

This article is based on Change Request (CR) 7637, which informs Medicare contractors that, effective for claims with Dates of Service on and after October 14, 2011, Medicare will cover annual depression screening for adults in the primary care setting.

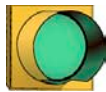


### CAUTION – What You Need to Know

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, 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. Effective October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For Dates of Service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly.



### GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding this change. Be sure your staffs are aware of this change.

## Background

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Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. These patients are important in the primary care setting because 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and

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39% were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Section 1861(d)(3) of the Social Security Act permits the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if all of the following criteria are met:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
- 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, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has 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 (ASCs), independent diagnostic testing facilities, Skilled Nursing Facilities (SNFs), inpatient rehabilitation facilities, and hospice are **not** considered primary care settings under this definition.
- Effective for claims with dates of service on and after April 2, 2012, 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

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- 49 - Independent clinic
- 71 - State or local public health clinic
- 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: Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.
- Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

## Claims Processing/Payment Information

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When claim line items for annual depression screening (G0444) are submitted with a POS code that is not applicable, they will be denied using:

- Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N428: "Not covered when performed in this place of service."
- Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file.

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- Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

RHCs using Type of Bill (TOB) 71X and FQHCs using TOB 77X may submit additional revenue lines containing G0444 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0444 separately with another encounter/visit on the same day billed on TOBs 71X or 77X. This does not apply, however, to claims with the Initial Preventive Physical Examination (IPPE) containing modifier 59 or to 77X claims containing Diabetes Self-Management Training or Medical Nutrition Training services. If G0444 is billed when an encounter/visit is billed with the same line item Date of Service, Medicare will assign:

- Group Code CO to the G0444 revenue line; and
- RARC 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13X) will be paid based on the Outpatient Prospective Payment System (OPPS). Those billed by Critical Access Hospitals (CAHs) on TOB 85X will be paid based on reasonable cost, except those G0444 services billed with revenue codes 096X, 097X, or 098X by Method II CAHs will receive 115% of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13X, 71X, 77X, or 85X will be denied using the following:

- CARC 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 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 assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These

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services are non-covered services because this is not deemed a “medical necessity” by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0444 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service, and, for TOB 13X, and TOB 85X when the revenue code is not 96X, 97X, or 98X, a claim for a facility fee. Claim lines for G0444 that exceed this limit will be denied using:

- CARC 119: “Benefit maximum for this time period or occurrence has been reached.”
- RARC N362: “The number of days or units exceeds our acceptable maximum.”
- Group Code PR 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 assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® Article MM7228 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service and the Multi-Carrier System Desktop Tool shall display the HCPCS G0444 depression screening sessions.

A MACs/FIs shall hold institutional claims received before April 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting HCPCS G0444.

## Additional Information

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The official instruction, CR7637, was issued to your carrier, FI, or A/B MAC regarding this change via two transmittals. The first transmittal updates the “National Coverage Determinations Manual” and is available at

<http://www.cms.gov/Transmittals/downloads/R139NCD.pdf> on the CMS Website.

The second transmittal is at

<http://www.cms.gov/Transmittals/downloads/R2431CP.pdf> and it updates the “Medicare Claims Processing Manual.”

If you have questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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