HCPCS Code G0442 Details

Code Symbols

C : Carrier judgment

Code Descriptor

Annual alcohol misuse screening, 15 minutes

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2020 National Physician Fee Schedule Relative Value File, GPCI20, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2020, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	January 01, 2020
Medicare Carrier/Locality:	NATIONAL
Conversion Factor:	36.0896

Note 1: Fee data is from the national MPFS files, which do not reflect the recent extension of the work geographic index floor to a minimum of 1.00. Check your MAC's site for more specific fee information. This tool will be updated once national Medicare updates its files.
Note 2: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status A
A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

Medicare Fees					
	National	**Adjusted**	**26**	**TC**	**53**
Facility	$9.74	$9.74	$0.00	$0.00	$0.00
Non Facility	$18.41	$18.41	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**

Work RVU:	0.18	0.18			0.00
PE RVU:	0.32	0.32			0.00
Malpractice RVU:	0.01	0.01			0.00
Total RVU:	0.51	0.51	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.18	0.18			0.00
PE RVU:	0.08	0.08			0.00
Malpractice RVU:	0.01	0.01			0.00
Total RVU:	0.27	0.27	0.00	0.00	0.00

Global & Other Info		
	Global Split	
Preoperative %:	0	
Intraoperative %:	0	
Postoperative %:	0	
Total RVU:	0	
Global Period (days):	XXX	
XXX = The global concept does not apply to the code.		
Radiology Diagnostic Tests :	99	
99 = Concept does not apply		
PC/TC Indicator :	0	
0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.		
Endoscopic Base Code :	None	

Modifier Guidelines		
	Modifier	**Rules(Click on rules for Details)**
MULT PROC	51	No multiple procedure payment adjustment

51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes

0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

BILAT SURG	50	No 150% bilateral payment boost

50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.

0 = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.

ASST SURG	80	Assistant payment allowed when supported

80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

CO-SURG	62	Co-surgeons not permitted

62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

0 = Co-surgeons not permitted for this procedure.

TEAM SURG	66	Team surgeons not permitted

66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

0 = Team surgeons not permitted for this procedure.

MINIMUM ASST SURG	81	Assistant payment allowed when supported.

81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment allowed when supported.
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2020 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: January 01, 2020

Services	MUE	MAI	MUE Rationale
Practitioner Services	1	2	CMS Policy
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	2	CMS Policy

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy
MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

Modifier Crossref

33, 59, 80, 81, 82, AF, AG, AK, AS, GC, KX, Q6, XE, XP, XS, XU,

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HCPCS Lay Terms

Use this code when the provider screens a patient for the presence of alcohol abuse. The provider performs this screening examination on an annual basis and the duration of the service lasts for 15 minutes.

Clinical Responsibility

A provider screens a patient for alcohol misuse. He provides this service to an individual who is currently experiencing physical, social, and psychological harm from alcohol use, but may not have a dependence problem. The provider offering the service is typically a primary care clinician in a primary care setting. The patient receives the service in the provider's office, outpatient hospital, or independent clinic. The service is time based and the provider will take 15 minutes for the interaction with the patient.

Alcohol abuse is a psychiatric condition in which alcohol consumption increases above the standard or recommended amount of drinking. Alcohol consumption is considered as harmful when general adult population consumes more than 14 drinks in a week or 4 drinks per occasion. For women and a person above 65 years of age, more than 7 drinks per week or more than 3 drinks per occasion can prove harmful.

Terminology

Alcohol Misuse:Psychiatric condition in which a person consumes more than standard amount of alcohol despite knowing the negative consequences; differs from alcohol dependence in that this person can stay without drinking for long periods of time but is unable to control himself once he starts to drink.

Screening: Examination of an apparently healthy person to detect the most typical signs of a disorder that may require further investigation.

Tips

The Healthcare Common Procedure Coding System, or HCPCS, codes that begin with a G identify professional health care procedures and services that would otherwise be coded in CPT® but for which there are typically no CPT® codes.

Medicare policies cover one screening session of annual alcohol misuse screening, 15 minute session.

Medicare does not cover this service, however, when provided by a psychiatrist. CMS will generally allow coverage for G0442 and G0443, Brief face–to–face behavioral counseling for alcohol misuse, 15 minutes only when the following provider specialties, who are on the provider's enrollment record, submit the services: General Practice, Family Practice, Internal Medicine, Obstetrics and Gynecology, Pediatric Medicine, Geriatric Medicine, Certified Nurse Midwife, Nurse Practitioner, Certified Clinical Nurse Specialist, and Physician Assistant.

Medicare covers G0442 once every 12 months and covers G0443 up to four times in a 12–month period, which begins on the date of service for G0442. Code G0442 must be billed first in order for subsequent claims for G0443 to be covered. Medicare also covers claims billed with G0442 and G0443 on the same day (exceptions: FQHCs and RHCs). Medicare will not pay for more than one service billed with G0443 on the same date. Refer to detailed payer guidelines from CMS for further guidance on coding and billing for G0442 and G0443.

In order to collect from the Medicare beneficiary for this service, you will need to have the patient sign an Advance Beneficiary Notice, or ABN, in advance of providing the service and submit your claim with modifier GA, Waiver of liability statement issued as required by payer policy, individual case appended to the code G0443 indicating that a signed ABN is on file.