CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3215	**Date: March 11, 2015**
	Change Request 8871

Transmittal 3127, dated November 19, 2014, is being rescinded and replaced by Transmittal 3215, dated March 11, 2015, to: (1) replace "January 1, 2015 MPFSDB" with "January 1, 2016 CLFS" in BR8871-04.1, (2) remove TOS 50 (FQHC) and 72 (RHC) from BR8871-04.9, (3) clarify payment method for 13X, add clarifying language for FQHC and RHC, and remove incorrect language regarding claims processing for FQHC and RHC in BR8871-04.10, (4) clarify MAC claims processing prior to January 1, 2016, in 8871-04.12, and, (5) make corresponding changes to the Claims Processing Manual. All other information remains the same.

SUBJECT: Screening for Hepatitis C Virus (HCV) in Adults

I. SUMMARY OF CHANGES: Effective for services performed on or after June 2, 2014, the Centers for Medicare & Medicaid Services will cover screening for hepatitis C virus consistent with the grade B recommendations by the USPSTF for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015 - For non-shared MAC edits and CWF analysis; April 6, 2015 - For remaining shared systems edits

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/Table of Contents
N	18/210/Screening for Hepatitis C Virus (HCV)
N	18/210.1/Institutional Billing Requirements
N	18/210.2/Professional Billing Requirements
N	18/210.3/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
N	18/210.4/Common Working File (CWF) Edits

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3215	Date: March 11, 2015	Change Request: 8871

Transmittal 3127, dated November 19, 2014, is being rescinded and replaced by Transmittal 3215, dated March 11, 2015, to: (1) replace "January 1, 2015 MPFSDB" with "January 1, 2016 CLFS" in BR8871-04.1, (2) remove TOS 50 (FQHC) and 72 (RHC) from BR8871-04.9, (3) clarify payment method for 13X, add clarifying language for FQHC and RHC, and remove incorrect language regarding claims processing for FQHC and RHC in BR8871-04.10, (4) clarify MAC claims processing prior to January 1, 2016, in 8871-04.12, and, (5) make corresponding changes to the Claims Processing Manual. All other information remains the same.

SUBJECT: Screening for Hepatitis C Virus (HCV) in Adults

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015 - For non-shared MAC edits and CWF analysis; April 6, 2015 - For remaining shared systems edits

I. GENERAL INFORMATION

A. Background: Prior to June 2, 2014, The Centers for Medicare & Medicaid Services (CMS) did not cover screening for hepatitis C virus (HCV) in adults.

Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

(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).

(3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for screening for HCV in adults and determined that the criteria listed above were met. Therefore, CMS will cover screening for HCV in adults under the conditions specified below.

B. Policy: Effective for claims with dates of service on or after June 2, 2014, CMS has determined the following: The evidence is adequate to conclude that screening for HCV, consistent with the grade B recommendations by the USPSTF, is reasonable and necessary for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Therefore, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. A screening test is covered for adults at high risk for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.

2. A single screening test is covered for adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965.

The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

NOTE: (1) For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk as defined in the policy, HCV screening is limited to once per lifetime. New HCPCS code G0472, short descriptor - Hep C screen high risk/other, and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. (Those born prior to 1945 or after 1965 with no risk factors are not eligible for this benefit.)

(2) For those beneficiaries determined to be high-risk initially as defined in the policy, regardless of birth year, ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented) is required in addition to HCPCS G0472.

(3) Coverage of a sub-set of the above high risk beneficiaries may occur on an annual basis if appropriate as defined in the policy, regardless of birth year, denoted by the presence of HCPCS G0472, ICD diagnosis code V69.8/Z72.89, and ICD-9 diagnosis code 304.91, unspecified drug dependence, continuous/ICD-10 diagnosis code F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented). Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

NOTE: Only HCPCS G0472 as noted above should be reported for this new HCV screening benefit. CPT code 86803, HCV rapid antibody test, is not appropriate for reporting screening under this policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8871 - 04.1	Effective for claims with dates of service on and after June 2, 2014, contractors shall recognize new HCPCS G0472, HCV screening, as a covered service. **NOTE:** HCPCS G0472, HCV screening, will be in the January 1, 2016, CLFS, and January 1, 2015 IOCE updates with an effective date of June	X	X			X				IOCE 1/1/15 CLFS 1/1/16

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2, 2014. **NOTE:** Refer to Pub. 100-03, Medicare National Coverage Determinations Manual, section 210.13 for coverage policy, and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 210, for claims processing instructions.									
8871 - 04.2	Effective for dates of service on and after June 2, 2014, contractors shall pay claims for HCV screening, HCPCS G0472, when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes 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			
8871 - 04.2.1	Contractors shall deny line-items with HCV screening, HCPCS G0472, ordered by provider specialty codes other than those listed in 8871-04.2 with the following: Claim Adjustment Reason Code (CARC) 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC) N574 - Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider. Medicare Summary Notice (MSN) 21.18 - This item or service is not covered when performed or ordered by this provider. 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). **NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8871 - 04.3	Effective for dates of service on and after June 2, 2014, beneficiary coinsurance and deductibles do not apply to claim lines containing HCV screening, HCPCS G0472.	X	X			X			X	
8871 - 04.4	Effective for claims with dates of service on or after June 2, 2014, Medicare contractors shall allow one HCV screening, HCPCS G0472, per lifetime, for adult beneficiaries who were born from 1945 through 1965 who are not considered high risk. **NOTE:** This edit shall be overridable.		X			X			X	
8871 - 04.4.1	Effective for claims with dates of service on or after June 2, 2014, contractors shall deny line-items on claims with HCV screening, HCPCS G0472, reported more than once in a lifetime for beneficiaries who do not meet the definition of high risk but were born from 1945 through 1965 using the following messages:	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD." MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision. Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión. Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file. **NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148									
8871 - 04.5	Effective for claims with dates of service on and after June 2, 2014, contractors shall allow payment for one HCV screening test for beneficiaries initially determined at high risk, regardless of birth year, when the claim is submitted with the following: • HCPCS G0472, and • ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented) **NOTE:** This edit shall be overridable.		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8871 - 04.5.1	Contractors shall line-item deny claims noted in 8871-04.5 without the appropriate HCPCS and diagnosis codes using the following messages: CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD." MSN 15.20 – "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision." Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión. Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file. **NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X	X							
8871 - 04.6	Effective for claims with dates of service on and after June 2, 2014, contractors shall allow payment for one <u>annual</u> HCV screening in adults at high risk, regardless of birth year, who have had continued illicit injection drug use since the prior negative screening test when the claim is submitted with the following: • HCPCS G0472, • ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89, and,		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented) **NOTE:** This edit shall be overridable. **NOTE:** 11 full months must elapse following the month in which the last negative HCV screening took place.									
8871 - 04.6.1	Effective for claims with dates of service on and after June 2, 2014, contractors shall deny line-items on claims for HCV screening, HCPCS G0472, that do not include the required coding noted in 8871-04.6 using the following messages: CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD." MSN 15.20 - "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision." Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión. Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8871 - 04.7	Contractors shall note the appropriate ICD-10 code(s) that are listed above. Contractors shall track the ICD-10 codes and ensure that the updated edit is turned on as part of ICD-10 implementation. **NOTE: Contractors will not receive a separate change request instructing you to implement the updated edits.**	X	X							
8871 - 04.8	When applying frequency limitations to HCV screening, HCPCS G0472, the contractor shall allow both a claim for the professional service and a claim for a facility fee.								X	
8871 - 04.8.1	Contractors shall identify the following institutional claims as facility fee claims for screening services: • Type of Bill (TOB) 13X Hospital Outpatient Departments, • TOB 71X Rural Health Clinics (RHCs) • TOB 77X Federally Qualified Health Centers (FQHCs) • TOB 85X Critical Access Hospitals (CAHs) when the revenue code is not 096X, 097X or 098X.								X	
8871 - 04.8.2	Contractors shall identify all other claims as professional service claims for screening services (professional claims, and institutional claims with TOB 85X when the revenue code is 096X, 097X, or 098X).								X	
8871 - 04.9	Contractors shall pay for HCV screening, HCPCS G0472, only when services are provided at the followings Place of Service (POS): 11- Physician's Office 22 - Outpatient Hospital 49 - Independent Clinic 71 - State or Local Public Health Clinic 81 – Independent Laboratory		X							
8871 - 04.9.1	Contractors shall deny line-items with HCV		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	screening, HCPCS G0472, and POS codes other than those listed in 8871-04.9 with the following messages: CARC 171 – Payment is denied when performed by this type of provider in this type of facility. 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 CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file. **NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.									
8871 - 04.10	Contractors shall pay for HCV screening, HCPCS G0472, on institutional claims in hospital outpatient departments (TOB 13X) based on the Outpatient Prospective Payment System, and in CAHs (TOB 85X) based on reasonable cost. **NOTE:** For RHCs and FQHCs that are authorized to bill under the all-inclusive rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC prospective payment system (PPS), payment for the professional component in included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs.	X				X				
8871 - 04.10.1	Contractors shall pay for HCV screening, HCPCS	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0472, with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the Medicare Physician Fee Schedule amount or the submitted charge.									
8871 - 04.10.2	Contractors shall deny line-items on claims for HCV screening, HCPCS G0472, when submitted on a TOB other than 13X, 71X, 77X, or 85X using the following messages: 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 N95 – "This provider type/provider specialty may not bill this 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 CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file. **NOTE:** For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X				X				
8871 - 04.11	Contractors shall calculate a next eligible date for HCV screening, HCPCS G0472, for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The calculation for preventive services next eligible date shall parallel claims processing.									
8871 - 04.11.1	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH, PRVN).					X			X	MBD, NGD
8871 - 04.11.2	When there is no next eligible date, the CWF provider query screens shall display this information in the date field to indicate why there is not a next eligible date.								X	
8871 - 04.11.3	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	
8871 - 04.11.4	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCV screening, HCPCS G0472, sessions in a format equivalent to the CWF HIMR screen.						X			
8871 - 04.11.5	The MCSDT shall display, on a separate screen and in a format equivalent to the CWF HIMR screen, HCV screening, HCPCS G0472.						X			
8871 - 04.12	Contractors shall apply contractor pricing to claims containing HCV screening, HCPCS G0472, with dates of service June 2, 2014 through December 31, 2015. Contractors shall not search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8871 - 04.13	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Pat Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Coverage), Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage), Michelle Issa, 410-786-6656 or michelle.issa@cms.hhs.gov Bridgitte Davis-Hawkins, 410-786-4573 or bridgitte.davis-hawkins@cms.hhs.gov (Practitioner Claims Processing), (Coverage), Bill Ruiz, 410-786-4573 or william.ruiz@cms.hhs.gov (Institutional Claims Processing)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 3215 Issued: 03-11-15)

210 – Screening for Hepatitis C Virus (HCV)

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

Effective for services furnished on or after June 2, 2014, Medicare covers screening for hepatitis C Virus (HCV) with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

A. Frequency

1. *A single, one-time HCV screening test is covered for adults who are not considered high risk as defined below, but who were born from 1945 through 1965. Those persons born prior to 1945 or after 1965 without high risk factors are not eligible for this benefit.*

2. *An initial screening for HCV is covered for adults at high risk for HCV infection regardless of birth year. "High risk" is defined as persons with a current or past history of illicit injection drug use and persons who have a history of receiving a blood transfusion prior to 1992.*

3. *Repeat HCV screening for a sub-set of high risk persons regardless of birth year is covered annually only for persons who have had continued illicit injection drug use since the prior negative HCV screening test.*

NOTE: *Annual means a full 11 months must elapse following the month in which the previous negative HCV screening took place.*

B. Determination of High Risk for Hepatitis C Disease

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

NOTE: *See Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, §210.13 for complete coverage guidelines.*

NOTE: *Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472, hepatitis C antibody screening for individual at high risk and other covered indication(s).*

NOTE: *Medicare Administrative Contractors shall contractor-price HCV screening claims, HCPCS G0472, with dates of service June 2, 2014 through December 31, 2015.*

210.1 – Institutional Billing Requirements

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

Effective for claims with dates of service on and after June 2, 2014, providers may use the following types of bill (TOBs) when submitting claims for screening for HCV screening, HCPCS G0472: 13X, 71X, 77X, and 85X. Service line-items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

-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 amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

NOTE: *For RHCs and FQHCs that are authorized to bill under the all-inclusive rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC prospective payment system (PPS), payment for the professional component in included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs.*

NOTE: *For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.*

210.2 – Professional Billing Requirements

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472, only when services are ordered 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

HCV screening services ordered by providers other than the specialty types noted above will be denied.

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472, 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
81 – Independent Laboratory

HCV screening claims submitted without one of the POS codes noted above will be denied.

210.3 – Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

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 HCV screening, HCPCS G0472:

- *Denying services submitted on a TOB other than 13X, 71X, 77X, or 85X:*

  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 N95 – This provider type/provider specialty may not bill this 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 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).

  NOTE: *For modifier GZ, use CARC 50 and MSN 8.81.*

- *Denying services where previous HCV screening, HCPCS G0472, is paid in history for claims with dates of service on and after June 2, 2014, and the patient is not deemed high risk by the presence of ICD-9 diagnosis code V69.8, other problems related to lifestyle/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91, unspecified drug dependence, continuous/ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated (once ICD-10 is implemented):*

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

  Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: *For modifier GZ, use CARC 50 and MSN 8.81.*

  NOTE: *This edit shall be overridable.*

- *Denying services for HCV screening, HCPCS G0472, for beneficiaries at high risk who have had continued illicit drug use since the prior negative screening test, when claims are not submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented), and/or 11 full months have not passed since the last negative HCV screening test:*

  CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

  Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  ***NOTE:** For modifier GZ, use CARC 50 and MSN 8.81.*

  ***NOTE:** This edit shall be overridable.*

- *Denying services for HCV screening, HCPCS G0472, for beneficiaries who do not meet the definition of high risk, but who were born from 1945 through 1965, when claims are submitted more than once in a lifetime:*

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

  RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

  MSN 15.20: "The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

  Spanish Version - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decision.

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  ***NOTE:** For modifier GZ, use CARC 50 and MSN 8.81.*

  ***NOTE:** This edit shall be overridable.*

- *Denying claim lines for HCV screening, HCPCS G0472, without the appropriate POS code:*

CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428 - Not covered when performed in certain settings.

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 CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

***NOTE:** For modifier GZ, use CARC 50 and MSN 8.81.*

- *Denying claim lines for HCV screening, HCPCS G0472, that are not ordered by an appropriate provider specialty:*

  CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.

  MSN 21.18 - This item or service is not covered when performed or ordered by this provider.

  Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  ***NOTE:** For modifier GZ, use CARC 50 and MSN 8.81.*

210.4 – Common Working File (CWF) Edits

(Rev. 3215, Issued: 03-11-15, Effective: 06-02-14, Implementation: 01-05-15 - For non-shared MAC edits and CWF analysis; 04-06-15 - For remaining shared systems edits)

The common working file (CWF) shall apply the following frequency limitations to HCV screening, HCPCS G0472:

One initial HCV screening, HCPCS G0472, for beneficiaries at high risk, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented),

Annual HCV screening, HCPCS G0472, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented),

Once in a lifetime HCV screening, HCPCS G0472, for beneficiaries who are not high risk who were born from 1945 through 1965.

NOTE: *These edits shall be overridable.*

When applying frequency limitations to HCV screening, HCPCS G0472, 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 this service: TOB 13X, TOB 71X, TOB 77X, and TOB 85X when the revenue code is not 096X, 097X, or 098X. CWF shall identify all other claims as professional service claims.