CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3461	**Date: February 5, 2016**
	Change Request 9403

SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

I. SUMMARY OF CHANGES: The purpose of this CR is to inform contractors that CMS has determined that the evidence is adequate to conclude that screening of HIV infection for all individuals between the ages of 15-65 years is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled in Part B.

EFFECTIVE DATE: April 13, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 7, 2016 - non-shared A/B MAC edits; July 5, 2016 - CWF analysis and design; October 3, 2016 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; January 3, 2017 - Requirement 9403.04.9

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	18/130.1/Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests
R	18/130.2/Billing Requirements
R	18/130.3/Payment Method
R	18/130.4/Types of Bill (TOBs) and Revenue Codes
R	18/130.5/Diagnosis Code Reporting
R	18/130.6/Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

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 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3461	Date: February 5, 2016	Change Request: 9403

SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

EFFECTIVE DATE: April 13, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 7, 2016 - non-shared A/B MAC edits; July 5, 2016 - CWF analysis and design; October 3, 2016 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; January 3, 2017 - Requirement 9403.04.9

I. GENERAL INFORMATION

A. Background: On January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) was authorized to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met (see section 1861(ddd) of the Social Security Act and implementing regulations at 42 CFR 410.64). One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the U.S. Preventive Services Task Force (USPSTF) and meets certain other requirements.

Previously, the USPSTF strongly recommended screening for all adolescents and adults at increased risk for human immunodeficiency virus (HIV) infection, as well as all pregnant women. The USPSTF made no recommendation for or against routine HIV screening in adolescents and adults not at increased risk for HIV infection. CMS issued a final decision supporting the USPSTF recommendations effective December 8, 2009. See Change Request (CR) 6786, Transmittal 1935, dated March 23, 2010, for earlier implementation instructions related to NCD210.7.

In April 2013, the USPSTF updated these recommendations and stated: "The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened (Grade A recommendation). The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown (Grade A recommendation). The HIV Testing Reimbursement Working Group, a sub-group of the HIV Healthcare Access Working Group and the Federal AIDS Policy Partnership, submitted an NCD reconsideration request asking CMS to review new scientific evidence and to adopt the USPSTF's most current evidence-based recommendations.

B. Policy: Effective for claims with dates of service on and after April 13, 2015, CMS has determined that the evidence is adequate to conclude that screening for HIV infection for all individuals between the ages of 15 and 65 years, as recommended with a Grade of A by the USPSTF, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

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

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual voluntary screening for all adolescents and adults between the age of 15 and 65, without regard to perceived risk.

2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:

- Men who have sex with men
- Men and women having unprotected vaginal or anal intercourse
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users
- Persons who have acquired or request testing for other sexually transmitted infectious diseases
- Persons with a history of blood transfusions between 1978 and 1985
- Persons who request an HIV test despite reporting no individual risk factors
- Persons with new sexual partners
- Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of "increased risk" for HIV infection is identified by the health care 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 recommendation should be a reflection of the service provided.

3. A maximum of three, voluntary HIV screenings of pregnant Medicare beneficiaries: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

NOTE: There is no co-insurance or deductible for tests paid under the Clinical Laboratory Fee Schedule (CLFS).

NOTE: The determination of the allowable frequency of billing for HIV screening HCPCS code G0475, shall include occurrences of billing on the behalf of the same beneficiary for the laboratory Obstetrics panel CPT-80081 within the previous 11 full month period.

NOTE: The following diagnosis codes are valid for this benefit:

ICD-9: V22.0 Supervision of normal first pregnancy

ICD-10: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester

Z34.01 Encounter for supervision of normal first pregnancy, first trimester

Z34.02 Encounter for supervision of normal first pregnancy, second trimester

Z34.03 Encounter for supervision of normal first pregnancy, third trimester

ICD-9: V22.1 Supervision of other normal pregnancy

ICD-10: Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester

Z34.81 Encounter for supervision of other normal pregnancy, first trimester

Z34.82 Encounter for supervision of other normal pregnancy, second trimester

Z34.83 Encounter for supervision of other normal pregnancy, third trimester

Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester

Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester

Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester

Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester

ICD-9: V23.9 Supervision of unspecified high-risk pregnancy

ICD-10: O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester

O09.91 Supervision of high risk pregnancy, unspecified, first trimester

O09.92 Supervision of high risk pregnancy, unspecified, second trimester

O09.93 Supervision of high risk pregnancy, unspecified, third trimester

V69.8 Other problems related to lifestyle/Z72.89 Other problems related to lifestyle

V73.89 Special screening examination for other specified viral diseases/Z11.4 Encounter for screening for human immunodeficiency virus [HIV]

V69.2 High risk sexual behavior/Z72.51 High risk heterosexual behavior/Z72.52High risk homosexual behavior/Z72.53 High risk bisexual behavior

NOTE: A new HCPCS code, G0475, HIV antigen/antibody, combination assay, screening, has been created for this benefit. I t will be effective retroactive back to the effective date of this policy, which is April 13, 2015, in the IOCE and OPPS updates. Code G0475 will be in the January 2016, Integrated Outpatient Code Editor (IOCE), the January 2016 Medicare Physician Fee Schedule Database (MPFSDB), and the January 2016 OPPS. G0475 will be contractor-priced from April 13, 2015, through December 31, 2016. Beginning January 1, 2017, G0475 will be priced and paid according to the CLFS.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9403 - 04.1	Effective for claims with dates of service on or after April 13, 2015, contractors shall recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening. **NOTE:** HCPCS code G0475 will appear in the January 1, 2017, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2016, Integrated Outpatient Code Editor (IOCE), in the January 2016 OPPS, and in the January 1, 2016, Medicare Physician Fee Schedule (MPFS). HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPPS. **NOTE:** Refer to Publication 100-03, Section 210.7 for coverage policy and Publication 100-04, Chapter 18, Section 130, for claims processing information. G0475 TOS=5	X	X							IOCE
9403 - 04.1.1	Contractors shall only accept claims with a Place of Service (POS) Code equal to 81 Independent Lab, and 11, Office.		X							
9403 - 04.2	Contractors shall not apply beneficiary co-insurance and deductibles to claim lines containing HCPCS code G0475, HIV screening.	X	X							
9403 - 04.3	Effective for claims with dates of service on or after April 13, 2015, contractors shall deny line-items on claims containing HCPCS code G0475, HIV screening, when billed more than once per annum [at least 11 full months must elapse from the date of the last screening,], or if the beneficiary's claim history shows claim lines containing CPT code 80081 submitted in the previous 11 full months, unless accompanied by	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	one of the diagnosis codes denoting pregnancy: ICD-9: V22.0 Supervision of normal first pregnancy ICD-10: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester									
9403 - 04.3.1	(Continuation of 4.3) ICD-9: V22.1 Supervision of other normal pregnancy ICD-10: Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester ICD-9: V23.9 Supervision of unspecified high-risk pregnancy ICD-10: O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester O09.91 Supervision of high risk pregnancy, unspecified, first trimester O09.92 Supervision of high risk pregnancy, unspecified, second trimester O09.93 Supervision of high risk pregnancy, unspecified, third trimester									
9403 - 04.3.2	When denying a line-item on the claim per requirement 9403-04.3 contractors shall use the following messages: Claim Adjustment Reason Code (CARC) 119: "Benefit maximum for this time period or occurrence has been reached." Remittance Advice Remark Code (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." Group Code: CO (Contractual Obligation)	X	X							
9403 - 04.3.3	(Continuation of 9403.04.3.2) (Part A only) Medicare Summary Notice (MSN) 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). **NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN. MSN 15.20: "The following policy NCD210.7 was used when we made this decision" Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."									
9403 - 04.4	Effective for claims with dates of service on or after April 13, 2015, contractors shall deny line-items with HCPCS code G0475, HIV screening, for beneficiaries between the ages of 15 and 65 without regard to risk, when not submitted with primary diagnosis code V73.89/Z11.4, as appropriate.	X	X			X			X	
9403 - 04.4.1	When denying a line-item on the claim per requirement 9403-04.4 contractors shall use 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.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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." Group Code: CO (Contractual Obligation)									
9403 - 04.4.2	(Continuation of 04.4.1) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). MSN 15.20: "The following policies NCD 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión." **NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.	X	X							
9403 - 04.5	Effective for claims with dates of service on or	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	after April 13, 2015, contractors shall deny line-items on claims containing HCPCS code G0475, HIV screening, for beneficiaries less than 15 and greater than 65 years of age with increased risk of HIV infection if the claim does not contain diagnosis code V73.89/Z11.4, as appropriate, as primary, and one of the following secondary diagnosis codes denoting high risk: V69.2/Z72.51 V69.8/Z72.89 V69.2/Z72.52 V69.2/Z72.53									
9403 - 04.5.1	When denying a line-item on the claim per requirement 9403-04.5 contractors shall use the following messages: CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present." RARC N129: "Not eligible due to the patient's age." Group Code: CO (Contractual Obligation) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). MSN 15.20: "The following policies NCD 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión." **NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.									
9403 - 04.6	Effective for claims with dates of service on or after April 13, 2015, contactors shall deny line-items on claims for pregnant beneficiaries denoted by a secondary diagnosis code in 04.3 above, if HCPCS code G0475,HIV screening, or CPT code 80081, and primary diagnosis code V73.89/ Z11.4, as appropriate, are not present on the claim.	X	X							
9403 - 04.6.1	When denying a line-item on the claim per requirement 9403-04.6, contractors shall use the following messages: CARC 11: The diagnosis is inconsistent with the procedure. 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."	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO (Contractual Obligation)									
9403 - 04.6.2	(Continuation of 4.6.1) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). MSN 15.20: "The following policies NCD 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión." **NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.	X	X							
9403 - 04.7	Effective for claims with dates of service on or after April 13, 2015, CWF shall allow no more than 3 HIV screening tests, HCPCS code G0475 or CPT code 80081, during each term of pregnancy beginning with the date of the 1st test. Claim lines shall also include primary diagnosis code V73.89/Z11.4, as appropriate, and one of the additional secondary diagnosis codes denoting pregnancy in 04.3 above.	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9403 - 04.7.1	When denying a line-item on the claim per requirement 9403-04.7 contractors shall use 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. Group Code: CO (Contractual Obligation)	X	X							
9403 - 04.7.2	(Continuation of 04.7.1) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD". Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227). MSN 15.20: "The following policies NCD 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	decisión." MSN: 15.22: "The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service. Spanish Version – "La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio." **NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.									
9403 - 04.8	FISS shall add logic that will include NCD's on the CWF reject edits.	X				X				
9403 - 04.9	Contractors shall pay for HCPCS code G0475, HIV screening, on institutional claims submitted on TOBs 12X, 13X, 14X, 22X and 23X based on the CLFS with dates of service on or after January 1, 2017.	X				X				
9403 - 04.10	Contractors shall pay for HCPCS code G0475, HIV screening, on institutional claims submitted on TOB 85X based on reasonable cost, for dates of service beginning on April 13, 2015.	X				X				
9403 - 04.11	Effective for claims with dates of service on and after April 13, 2015, CWF shall update Major Category IV for SNF CB to include HCPCS code G0475, HIV screening, to allow only 22X bill types to bypass SNF CB edits.								X	
9403 - 04.12	CWF shall calculate a next eligible date for HCPCS code G0475, HIV screening, for a given beneficiary. The calculation shall include all applicable factors including:								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Beneficiary Part B entitlement status • Beneficiary claims history • To include any claims in history for the beneficiary containing CPT-80081 (Obstetric panel) • Utilization rules **NOTE:** The calculation for preventive services next eligible date shall parallel claims processing.									
9403 - 04.13	The next eligible date shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, PRVN).					X			X	MBD, NGD
9403 - 04.13.1	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	
9403 - 04.14	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	
9403 - 04.15	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCPCS code G0475, HIV screening, on a separate screen and in a format equivalent to the CWF HIMR screen.		X				X			
9403 - 04.16	Contractors shall apply contractor pricing for HCPCS code G0475, HIV screening, for claims with dates of service on and after April 13, 2015, through December 31, 2016, on TOBs 12X, 13X, 14X, 22X and 23X.	X								
9403 - 04.17	Contractors shall not search for claims containing HCPCS code G0475, HIV screening, with dates of service on or after April 13, 2015, but contractors may adjust claims that are brought to their attention.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9403 - 04.18	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 5 business days after receipt of the notification from CMS announcing the availability of the 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): Stuart Caplan, 410-786-8564 or stuart.caplan@cms.hhs.gov (Coverage) , Wendy Knarr, 410-786-0843 or Wendy.Knarr@cms.hhs.gov (Supplier Claims Processing) , Shauntari Cheely, 410-786-1818 or Shauntari.Cheely@cms.hhs.gov (Part A Institutional Claims Processing) , Ian Kramer, 410-786-5777 or Ian.Kramer@cms.hhs.gov (Practitioner Claims Processing Part B) , Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage) , Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocatosimons@cms.hhs.gov (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's 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

130.1 - Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

Effective for claims with dates of service on and after December 8, 2009, implemented with the April 5, 2010, IOCE, the following HCPCS codes are to be billed for human immunodeficiency *virus* (HIV) screening:

- G0432- Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening,

- G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and,

- G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

Effective for claims with dates of service on or after April 13, 2015, the following HCPCS code may be billed for HIV screening:

- *G0475 - HIV antigen/antibody, combination assay, screening*

130.2 - Billing Requirements

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

Medicare Administrative Contractors (MACs) shall recognize the above HCPCS codes for HIV screening *in accordance with Publication 100-03, Medicare National Coverage Determinations Manual, section 210.7.*

Effective for claims with dates of service on and after December 8, 2009, MACs shall pay for voluntary HIV screening as follows:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,

- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Claims that are submitted for HIV screening shall be submitted in the following manner:

For beneficiaries reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 (Special screening for other specified viral disease) as primary, and V69.8 (Other problems related to lifestyle), as secondary.

For beneficiaries not reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 as primary, and one of the following ICD-9 diagnosis codes: V22.0 (Supervision of

normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy), as secondary.

Effective for claims with dates of service on or after April 13, 2015, MACs shall also pay for voluntary, HIV screening as follows (replacing ICD-9 with ICD-10 beginning October 1, 2015):

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0475 or CPT-80081 with primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, along with one of the following ICD-9/ICD-10 diagnosis codes as secondary listed below, and allow no more than 3 HIV screening tests during each term of pregnancy beginning with the date of the 1st test:

ICD-9: V22.0 Supervision of normal first pregnancy
ICD-10: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Z34.02 Encounter for supervision of normal first pregnancy, second trimester
Z34.03 Encounter for supervision of normal first pregnancy, third trimester
ICD-9: V22.1 Supervision of other normal pregnancy
ICD-10: Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81 Encounter for supervision of other normal pregnancy, first trimester
Z34.82 Encounter for supervision of other normal pregnancy, second trimester
Z34.83 Encounter for supervision of other normal pregnancy, third trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester
ICD-9: V23.9 Supervision of unspecified high-risk pregnancy
ICD-10: O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91 Supervision of high risk pregnancy, unspecified, first trimester
O09.92 Supervision of high risk pregnancy, unspecified, second trimester
O09.93 Supervision of high risk pregnancy, unspecified, third trimester

Claims shall contain HCPCS code G0475 for beneficiaries between 15 and 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary regardless of risk factors. If primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present and the beneficiary is between 15 and 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

Claims shall contain HCPCS code G0475 for beneficiaries less than 15 and greater than 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/ Z11.4 as primary, and one of the following secondary ICD-9/ICD-10 diagnosis codes:

V69.8 (Other problems related to lifestyle)/Z72.89 (Other problems related to lifestyle)
Z72.51 (High risk heterosexual behavior)
Z72.52 (High risk homosexual behavior)
Z72.53 (High risk bisexual behavior)

If ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present as primary and one of the ICD-9/ICD-10 secondary codes listed above is not present and the beneficiary is less than 15 or greater than 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

130.3 - Payment Method

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

Payment for HIV screening, *HCPCS codes G0432, G0433, G0435*, is under the Medicare Clinical Laboratory Fee Schedule *(CLFS)* for *Types of Bill (*TOB) 12X, 13X, 14X, 22X, and 23X beginning January 1, 2011. For TOB 85X payment is based on reasonable cost. Deductible and coinsurance do not apply. Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted procedure code 87999. Between April 5, 2010, and January 1, 2011, *HCPCS codes G0432, G0433, and G0435* will be contractor priced.

Payment for HIV screening, HCPCS code G0475, for institutional claims will be under the Medicare CLFS for TOB 12X, 13X, 14X, 22X, and 23X for claims on or after January 1, 2017. For TOB 85X payment is based on reasonable cost.

Effective for claims with date of service from April 13, 2015 through December 31, 2016, HCPCS code G0475 will be contractor priced. Beginning with date of service January 1, 2017 and after, HCPCS code G0475 will be priced and paid according to the CLFS.

HCPCS code G0475 will be included in the January 2017 CLFS, January 1, 2016 IOCE, the January 2016 OPPS and January 1, 2016 MPFSD. HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPPS.

A/B MACs (B) shall only accept claims submitted with a G0475 with a Place of Service (POS) Code equal to 81 Independent Lab, and 11, Office.

Deductible and coinsurance do not apply.

130.4 - Types of Bill (TOBs) and Revenue Codes

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

The applicable bill types for HIV screening, *HCPCS codes G0432, G0433, G0435, and G0475* are: 12X, 13X, 14X, 22X, 23X, and 85X. (Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.) Use revenue code 030X (laboratory, clinical diagnostic).

A/B MACs (A) shall apply contractor pricing for HCPCS code G0475, HIV screening, for claims with dates of service on and after April 13, 2015 through December 31, 2016.

130.5 - Diagnosis Code Reporting

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims where increased risk factors are reported: *ICD-9/ICD-10 diagnosis code* V73.89/*Z11.4* as primary and *ICD-9/ICD-10 diagnosis code* V69.8/*Z72.89, Z72.51, Z72.52, or Z72.53,* as secondary.

b. For claims where increased risk factors are NOT reported: *ICD-9/ICD-10 diagnosis code* V73.89/*Z11.4* as primary only.

c. For claims for pregnant Medicare beneficiaries, the following *secondary* diagnosis codes shall be submitted in addition to *primary ICD-9/ICD-10 diagnosis code* V73.89/*Z11.4* to allow for more frequent screening than once per 12-month *period*:

ICD-9: *V22.0 Supervision of normal first pregnancy*
ICD-10: *Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01 Encounter for supervision of normal first pregnancy, first trimester
Z34.02 Encounter for supervision of normal first pregnancy, second trimester
Z34.03 Encounter for supervision of normal first pregnancy, third trimester
ICD-9: *V22.1 Supervision of other normal pregnancy*
ICD-10: *Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81 Encounter for supervision of other normal pregnancy, first trimester
34.82 Encounter for supervision of other normal pregnancy, second trimester
Z34.83 Encounter for supervision of other normal pregnancy, third trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester
ICD-9: *V23.9 Supervision of unspecified high-risk pregnancy*
ICD-10: *O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91 Supervision of high risk pregnancy, unspecified, first trimester
O09.92 Supervision of high risk pregnancy, unspecified, second trimester
O09.93 Supervision of high risk pregnancy, unspecified, third trimester

130.6 - Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

- When denying claims for HIV screening, *HCPCS codes G0432, G0433, or G0435,* submitted without ICD-9/ICD-10 diagnosis codes V73.89/*Z11.4*, or V73.89/*Z11.4* and V69.8/*Z72.89*, use the following messages:

  Medicare Summary Notice (MSN) 16.10 - Medicare does not pay for this item or service.

  "Medicare no paga por este articulo o servicio"

  Claim Adjustment Reason Code (CARC) 167- This (these) diagnosis(es) is (are) not covered.

  Group Code CO - (Contractual Obligation)

- When denying claims for HIV screening, *HCPCS codes G0432, G0433, or G0435, over the benefit maximum,* use the following denial messages:

  MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

"La informacíón proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio."

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

Group Code CO - (Contractual obligation).

- *Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475 or CPT-80081 for more than three in a pregnancy term, use the following denial messages:*

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

Remittance Advice Remark Code (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.

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800 MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."

***NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.*

MSN: 15.22: "The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

Spanish Version – "La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio."

Group Code - CO

- *Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following secondary ICD-9/ICD-10 diagnosis codes: V69.2/Z72.51, V69.8/Z72.89, V69.2/Z72.52, or V69.2/Z72.53 are not present and the beneficiary is less than 15 and greater than 65 years of age, use the following messages:*

CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N129: "Not eligible due to the patient's age."

(Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

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***NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.*

Group Code - CO

- *Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, not submitted with the appropriate, primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, regardless of the presence of risk factor, use 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). A n 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."

  (Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

  MSN 15.20: "The following policies NCD210.7 were used when we made this decision."

  Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."

  ***NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.*

  Group Code - CO

- *Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, billed more than once per annum [at least 11 full months must elapse from the date of the last screening], use 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."

  (Part A Only)MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

  MSN 15.20: "The following policy NCD210.7 was used when we made this decision"

  Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decisión."

  ***NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.*

  Group Code - CO

  - *Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS G0475,or CPT-80081 if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following ICD-9/ICD-10 secondary diagnosis codes are not present for pregnant beneficiaries as listed in section 130.5 (c), use the following denial messages:*

  CARC 11: The diagnosis is inconsistent with the procedure. 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."

  Group Code CO

  (Part A Only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD".

  Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir a Medicare lo que está cubierto. Un LCD se usó para su reclamación. Usted puede comparar su caso con la

determinación y enviar información de su médico si piensa que puede cambiar nuestra decisión. Para obtener una copia del LCD, llame al 1-800-MEDICARE (1-800-633-4227).

MSN 15.20: "The following policies NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó esta decision."

***NOTE:** Due to system requirement, FISS has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.*