CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3393	**Date: November 5, 2015**
	Change Request 9360

SUBJECT: Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults

I. SUMMARY OF CHANGES: Transmittal 3215, Change Request (CR) 8871 titled "Screening for Hepatitis C Virus (HCV) in Adults" omitted TOB 014x from the list of applicable TOBs for the screening of HCV. This CR adds TOB 014x as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen.

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/210/210.1/Institutional Billing Requirements
R	18/210/210.3/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

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: 3393	Date: November 5, 2015	Change Request: 9360

SUBJECT: Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2016

I. GENERAL INFORMATION

A. Background: Transmittal 3215, Change Request (CR) 8871 titled "Screening for Hepatitis C Virus (HCV) in Adults" omitted TOB 014x from the list of applicable TOBs for the screening of HCV. This CR adds TOB 014x as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen. Appropriate TOBs for the screening of HCV other than non-patient laboratory specimen remains the same. They are 013x and 085x.

B. Policy: Providers report TOB 014x when submitting claims for Screening for HCV when provided to non-patient laboratory specimens.

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	
9360.1	Effective for claims with dates of service on and after June 2, 2014, contractors shall instruct providers to report TOB 014x when submitting claims for HCPCS code G0472 when provided to non-patient laboratory specimens.	X								
9360.2	Contractors shall add TOB 014X to existing editing for HCPCS code G0472. NOTE: Contractors shall apply same logic addressed in CRs 8871 and 9200 for G0472.								X	
9360.3	Effective for claims with dates of service on or after June 2, 2014, contractors shall allow TOB 014x on institutional claims containing HCPCS code G0472.	X				X			X	
9360.4	Contractors shall pay for claims containing HCPCS code G0472 reported on TOB 014x based on the laboratory fee schedule.	X				X				IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9360.5	Contractors shall not search for claims with HCPCS code G0472, submitted under TOB 014x with dates of service on or after June 2, 2014 but received before April 4, 2016, but contractors may adjust claims that are brought to their attention.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9360.6	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				

IV. SUPPORTING INFORMATION

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

"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): William Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov

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

210.1 – Institutional Billing Requirements

(Rev.3393, Issued: 11-05-15, Effective: 06- 02-14, Implementation: 04-04-16)

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, *14X,* 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)
- *Non-patient laboratory specimen – TOB 14X – based on laboratory fee schedule*
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost

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.

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

(Rev.3393, Issued: 11-05-15, Effective: 06- 02-14, Implementation: 04-04-16)

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, *14X,* 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*, Group Code CO,* 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 NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

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).

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.

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

  NOTE: This edit shall be overridable.

- Denying services for HCV screening, 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 NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

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).

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 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, *Group Code CO,* and MSN 8.81.

NOTE: This edit shall be overridable.

- Denying claim lines for HCV screening, 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, *Group Code CO,* and MSN 8.81.

- Denying claim lines for HCV screening, G0472, that are not submitted from the appropriate provider specialties:

  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, *Group Code CO,* and MSN 8.81.

- Denying claim lines for HCV screening, HCPCS G0472, if beneficiary born prior to 1945 and after 1965 who are not at high risk (absence of V69.8 /ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented) or 304.91/ ICD-10 diagnosis code F19.20 (once ICD-10 is implemented)):

  CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) 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 15.19 - 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 NCD210.13 were used when we made this decision.

  Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo 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.

  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).