CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3615	**Date: September 23, 2016**
	Change Request 9778

SUBJECT: Update to Hepatitis B Deductible and Coinsurance and Screening Pap Smears Claims Processing Information

I. SUMMARY OF CHANGES: This change request updates language regarding coinsurance and deductible for hepatitis B in Pub. 100-04, chapter 18, section 10. In addition, this CR removes sub-section D in sections 30.8 and 30.9.

EFFECTIVE DATE: December 27, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 27, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/10/Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
R	18/30/30.8/MSN Messages
R	18/30/30.9/Remittance Advice Codes

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: 3615	Date: September 23, 2016	Change Request: 9778

SUBJECT: Update to Hepatitis B Deductible and Coinsurance and Screening Pap Smears Claims Processing Information

EFFECTIVE DATE: December 27, 2016
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I. GENERAL INFORMATION

A. Background: Section 10 of Pub. 100-04, chapter 18 contains erroneous information regarding coinsurance and deductible for hepatitis B virus vaccine. Currently, coinsurance and deductible for hepatitis B virus vaccine are waived. In addition, sections 30.8 and 30.9 contain incorrect claims processing instructions for screening Pap smears. This CR updates language regarding coinsurance and deductible for hepatitis B virus vaccine and removes sub-section D from sections 30.8 and 30.9.

B. Policy: No change in policy.

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	
9778.1	Contractors shall note revisions made to Pub. 100-04, chapter 18, sections 10, 30.8, and 30.9.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9778.2	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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Bill 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

10 - Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

(Rev. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

For A/B MACs *(B)*, Part B of Medicare pays 100 percent of the Medicare allowed amount for pneumococcal, influenza, *and hepatitis B* virus vaccines and their administration.

Part B deductible and coinsurance do not apply for pneumococcal, influenza, *and hepatitis* virus vaccine.

State laws governing who may administer pneumococcal and influenza virus vaccinations and how the vaccines may be transported vary widely. Medicare contractors should instruct physicians, suppliers, and providers to become familiar with state regulations for all vaccines in the areas where they will be immunizing.

30.8 - MSN Messages

(Rev. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed use MSN 18.17:

> Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 full months (59 months total) must elapse from the date of the last screening], use the following messages:

(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 210.2.1 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión.”

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, use the following messages:

(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 210.2.1 were used when we made this decision."

Spanish Version – “Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión.”

C. If denying line-items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-9 or ICD-10 diagnosis codes listed below:

ICD-9: V73.81 and V72.31

ICD-10: Z11.51 and Z01.411 or, Z01.419

Use the following messages:

(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 210.2.1 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD 210.2.1 fueron utilizadas cuando se tomó esta decisión.”

30.9 - Remittance Advice Codes

(Rev. 3615, Issued: 09-23-16, Effective: 12-27-16, Implementation: 12-27-16)

Pap Smear Screening: If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - “Benefit maximum for this time period has been reached” at the line level, and
- Remark code M83 - “Service is not covered unless the patient is classified as at high risk” at the line item level.

HPV Screening: Effective for claims with dates of service on and after July 9, 2015:

A. If denying line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a 5-year period [at least 4 years and 11 months (59 months total) 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.”

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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).

B. If denying line-items on claims containing HCPCS G0476, HPV screening, when the beneficiary is not between the ages of 30-65, 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 PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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).

C. If denying line-items on claims containing HCPCS G0476, HPV screening, when the claim does not contain the appropriate ICD-9 or ICD-10 diagnosis codes listed below:

ICD-9: V73.81 and V72.31

ICD-10: Z11.51 and Z01.411, or, Z01.419

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). 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 assigning financial liability to the provider