CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3285	**Date: June 19, 2015**
	Change Request 9200

SUBJECT: Screening for Hepatitis C Virus (HCV) in Adults – Implementation of Additional Common Working File (CWF) and Shared System Maintainer (SSMs) Edits

I. SUMMARY OF CHANGES: This Change Request (CR) is a follow-up to CR 8871, Transmittal 3215 dated March 11, 2015, entitled Screening for Hepatitis C Virus (HCV) in Adults.

CR 9200 addresses the line-item denial of HCV claims for those born outside the years 1945-1965 that do not have a high risk indicator as this population is not eligible for the HCV screening benefit.

CR 9200 also clarifies/revises from CR 8871, Transmittal 3215 the correct use of MSN messages 15.19 & 15.20, removes TOBs/payment instructions/modifies editing for: RHCs 71X, FQHCs 77X, and CAH 85X Method II professional services (with revenue code 096X, 097X, or 098X) .

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF 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	18/210.1/Institutional Billing Requirements
R	18/210.3/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	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

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: 3285	Date: June 19, 2015	Change Request: 9200

SUBJECT: Screening for Hepatitis C Virus (HCV) in Adults – Implementation of Additional Common Working File (CWF) and Shared System Maintainer (SSMs) Edits

EFFECTIVE DATE: June 2, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems edits

I. GENERAL INFORMATION

A. Background: Effective for claims with dates of services performed on or after June 2, 2014, the Centers for Medicare & Medicaid Services covers screening for hepatitis C virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force 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. This policy was implemented in Change Request (CR) 8871, Transmittal 3215, dated March 11, 2015.

B. Policy: As indicated in CR 8871, and replicated here for ease of reference only (for these claims processing instructions see CR 8871), CMS covers 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, and this is the edit being implemented with this follow-up CR to CR 8871.)

(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.

(4) HCV screening, HCPCS code G0472, is a technical service only and there is no professional fee. CR 8871, Transmittal 3215, provided claims processing instructions for G0472 when submitted on TOBs 71X (RHC), 77X (FQHC), and 85X with revenue code 096X, 097X, or 098X (CAHs Method II). This change request removes TOBs 71X, 77X and 85X with revenue code 096X, 097X, or 098X as a valid TOB for HCV HCPCS code G0472.

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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9200.1	Effective for claims with dates of service on and after June 2, 2014, contractors shall be aware of the following clarification: Where MSN 15.20 is indicated in previous HCV screening CR 8871, requirements 04.4.1, 04.5.1 and 04.6.1: "The following policies NCD 210.13 were used when we made this decision." Spanish Version - Las siguientes políticas NCD 210.13 fueron utilizadas cuando se tomó esta decisión. The following language clarification is added: 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.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
9200.2	Effective for claims with dates of service on and after June 2, 2014, contractors shall line-item deny HCPCS G0472 screening as a covered service for: - Adult beneficiaries born prior to 1945 and after 1965, who are not high risk (absence of V69.8 or V69.8/ ICD-10 diagnosis code Z72.89 and 304.91/ICD-10 diagnosis code F19.20). **NOTE:** This edit shall be overridable.					X			X	
9200.2.1	Contractors shall line-item deny claims for HCV screening, HCPCS G0472, that do not meet requirements in 9200.2 with the following messages: 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	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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).									
9200.2.1.1	(continuation of 2.1) Contractors shall use the following MSN message in addition to MSN 15.19, as instructed in 9200.2, when line-item denying claims for HCV screening, HCPCS G0472, that do not meet requirements in 9200.2: 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	X								
9200.2.2	Contractors shall line-item deny claims for HCV screening, HCPCS G0472, that do not meet requirements in 9200.2 with the following messages: 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 CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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. Group code - CO assigning financial liability to the provider									
9200.3	Contractors shall remove the following types of bill (TOBs) as valid for HCV screening services, HCPCS G0472, as initially indicated as valid TOBs in CR 8871: • TOB 71X Rural Health Clinics (RHCs) • TOB 77X Federally Qualified Health Centers (FQHCs) • TOB 85X Critical Access Hospitals (CAHs) Method II professional services with revenue code 096X, 097X, or 098X.								X	
9200.4	Contractors shall remove claims processing instructions regarding payment of HCV screening services, HCPCS G0472, as initially indicated in CR 8871, for: • RHCs, • FQHCs, and • CAH Method II with revenue code 096X, 097x, or 098X.	X								
9200.5	Contractors shall modify current editing for HCV screening services, HCPCS G0472, as initially indicated in CR 8871, by removing TOBs 71X, 77X, and 85X Method	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	II professional services with revenue code 096X, 097X, or 098X.									
9200.6	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		
9200.7	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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9200.1	CR 8871, Transmittal 3215 dated March 11, 2015.

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

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr, 410-786-0843 or wendy.knarr@cms.hhs.gov (Supplier Claims), William Ruiz, 410-786-4573 or william.ruiz@cms.hhs.gov (Institutional Claims Processing), Bridgitte Davis-Hawkins, 410-786-4573 or bridgitte.davis-hawkins@cms.hhs.gov (Practitioner Claims Processing), Michelle Issa, 410-786-6656 or michelle.issa@cms.hhs.gov (Coverage), 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

210.1 – Institutional Billing Requirements

(Rev. 3285, Issued: 06-19-15, Effective: 06-02-14, Implementation: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems)

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 HCV screening, HCPCS G0472: 13X 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

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. 3285, Issued: 06-19-15, Effective: 06-02-14, Implementation: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems)

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 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 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 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 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 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 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 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.

- *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).

210.4 – Common Working File (CWF) Edits

(Rev. 3285, Issued: 06-19-15, Effective: 06-02-14, Implementation: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems)

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.

***NOTE:** HCV screening, HCPCS G0472 is not a covered service for beneficiaries 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) and/or 304.91/ ICD-10 diagnosis code F19.20 (once ICD-10 is implemented)).*