

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Implementation Date: January 5, 2015, for non-shared MAC edits and CWF analysis; April 6, 2015, for remaining shared system edits

Screening for Hepatitis C Virus (HCV) in Adults

Note: This article was revised on April 28, 2016, to add a link to a related article ([SE1604](#)) that summarizes the available substance abuse treatment services and provides reference links to other online Medicare information with further details about these services. All other information remains the same

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Hepatitis C Virus (HCV) screening services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for Hepatitis C Virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

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Background

Hepatitis C Virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) 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. 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. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

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.

General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:

1. New HCPCS 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. HCPCS G0472 will appear in the January 2016 recurring updates of the Clinical Laboratory Fee Schedule (CLFS) and the Integrated Outpatient Code Editor (IOCE) with a June 2, 2014, effective date. MACs shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2015, that contain

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HCPCS G0472. MACs will not automatically adjust claims that may be processed in error, but will adjust such claims that you bring to their attention.

2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with HCPCS G0472.
4. For those determined to be high-risk initially, claims must be submitted with:
 - HCPCS G0472
 - 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)
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
 - HCPCS G0472
 - ICD diagnosis code V69.8/Z72.89
 - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented)

NOTE: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional Billing Requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13X, 71X, 77X, and 85X when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim Adjustment Reason Code (CARC) 170 -Payment 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
- Remittance Advice Remarks Code (RARC) N95 - This provider type/provider specialty may not bill this service
- Group Code CO (contractual obligation) – If claim received without a GZ modifier

The service is paid on the following basis:

- Outpatient hospitals – TOB 13X - based on the Outpatient Prospective Payment System
- Rural Health Clinics (RHCs) - TOB 71X - and Federally Qualified Health Centers (FQHCs) - 77X - For RHCs and FQHCs that are authorized to bill under the All-Inclusive Rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC Prospective Payment System (PPS),

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payment for the professional component is included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs

- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost
- CAH Method II – TOB 85X - based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

Professional Billing Requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 - Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service. 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/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- Group Code CO if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

- 11 - Physician's Office
- 22 - Outpatient Hospital
- 49 - Independent Clinic
- 71 - State or Local Public Health Clinic
- 81 - Independent Laboratory

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

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- CARC 171 - Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- RARC N428 - Not covered when performed in this place of service
- Group Code – CO if claim received without GZ modifier

Other Billing Information for Both Professional and Institutional Claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- 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 on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD
- Group Code - CO if claim received without GZ modifier

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 **and** 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening)
- 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. (for subsequent annual high risk screening)
- 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 on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD
- Group Code CO if claim received without GZ modifier

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Additional Information

The official instruction, CR8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the "Medicare Claims Processing Manual" and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3215CP.pdf> on the CMS website. The second transmittal updates the "NCD Manual" and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R177NCD.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Document History

Date of Change	Description
April 28, 2016	The article was revised to add a link to a related article (SE1604) that summarizes the available substance abuse treatment services and provides reference links to other online Medicare information with further details about these services. All other information remains the same.
March 13, 2015	The article was revised to reflect the revised CR8871 issued on March 11. The article was revised to (1) replace "January 1, 2015 MPFSDB" with "January 1, 2016 CLFS" on page 3, (2) remove 50 (FQHC) and 72 (RHC) from the list of place of service codes in the middle of page 5, (3) clarify payment method for Type of Bill 13X, (4)add clarifying language for FQHC and RHC, and remove incorrect language regarding claims processing for FQHC and RHC, (5) clarify MAC claims processing prior to January 1, 2016, instead of January 1, 2015 on page 3.

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