CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13680	**Date: March 26, 2026**
	Change Request 14408

SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapter 18, Sections 210-210.4 in Reference to Change Request (CR) 14388 "Billing Code Clarification for National Coverage Determination (NCD) 210.13 Screening for Hepatitis C Virus (HCV) in Adults"

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update IOM 100-04, Chapter 18, Sections 210–210.4 to align with CR 14388 with respect to NCD 210.13.

EFFECTIVE DATE: October 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2026

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/Screening for Hepatitis C Virus (HCV)
R	18/210/210.1/Institutional Billing Requirements
R	18/210/210.2/Professional 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
R	18/210/210.4/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: 13680	Date: March 26, 2026	Change Request: 14408

SUBJECT: Update to the Internet Only Manual (IOM) Publication 100-04, Chapter 18, Sections 210-210.4 in Reference to Change Request (CR) 14388 "Billing Code Clarification for National Coverage Determination (NCD) 210.13 Screening for Hepatitis C Virus (HCV) in Adults"

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update IOM 100-04, Chapter 18, Sections 210–210.4 to align with CR 14388 with respect to NCD 210.13.

II. GENERAL INFORMATION

A. Background: This Change Request (CR) updates the billing requirements in Pub. 100-04, Chapter 18, Sections 210–210.4 of the Medicare Claims Processing Manual. The revisions reflect CR 14388, "Billing Code Clarification for National Coverage Determination (NCD) 210.13 – Screening for Hepatitis C Virus (HCV) in Adults."

Specifically, CR14388 is revised to add HCPCS code G0567, payable with or without modifier QW, effective June 27, 2024 (Pub. 100-04, Chapter 18, Sections 210–210.4).

B. Policy: N/A

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14408.1	Contractors shall be aware that HCPCS code G0567, with or without modifier QW, has been added to Pub. 100-04, Chapter 18, Sections 210–210.4, effective June 27, 2024. Note: Professional claims: HCPCS code G0567 with or without modifier QW.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to

relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. 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

VI. CONTACTS

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

VII. 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

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 13680; Issued: 03-26-26)

210 - Screening for Hepatitis C Virus (HCV)

(Rev. 13680; Issued: 03-26-26; Effective: 10-01-25; Implementation: 07-06-26)

Effective for services furnished on or after June 2, 2014, Medicare covers screening for hepatitis C Virus (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:

A. Frequency

1. A single, one-time HCV screening test is covered for adults who are not considered high risk as defined below, but who were born from 1945 through 1965. *Individuals* born prior to 1945 or after 1965 without high risk factors are not eligible for this benefit.

2. An initial screening for HCV is covered for adults at high risk for HCV infection, regardless of birth year. "High risk" is defined as *individuals* with a current or past history of illicit injection drug use, *as well as individuals who received a blood transfusion prior to 1992.*

3. *Annual* repeat HCV screening *is covered* for a subset of high-risk *individuals*, regardless of birth year, *but* only for *those* who have continued illicit injection drug use since a prior negative HCV screening test.

NOTE: Annual means a full 11 months must elapse following the month in which the previous negative HCV screening took place.

B. Determination of High Risk for Hepatitis C Disease

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 *reflect* the service provided.

NOTE: See Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, §210.13 for complete coverage guidelines.

NOTE: Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472 *and G0567 (effective 06/27/24*).

NOTE: A/B MACs (B) shall contractor-price HCV screening claims, HCPCS G0472, with dates of service June 2, 2014, through December 31, 2015.

210.1 – Institutional Billing Requirements

(Rev. 13680; Issued: 03-26-26; Effective: 10-01-25; Implementation: 07-06-26)

Effective for claims with dates of service on and after June 2, 2014, providers may use the following types of bills (TOBs) when submitting claims for screening for HCV screening, HCPCS G0472 *or G0567 (effective 06/27/24)*: 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 – *(facility/technical)* based on reasonable cost
- *Critical Access Hospitals (CAH Method II) - TOB 85X and Revenue codes 096X, 097X and 098X based on 115% of the lesser of the fee schedule amount of the submitted charge.*

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.

210.2 - Professional Billing Requirements

(Rev. 13680; Issued: 03-26-26; Effective: 10-01-25; Implementation: 07-06-26)

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472 *or G0567 with or without modifier QW (effective 06/27/24),* only when services are ordered 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

HCV screening services ordered by providers other than the specialty types noted above will be denied.

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472 *or G0567 with or without modifier QW (effective 06/27/24)*, only when submitted with one of the following places of service (POS) codes:

11 - Physician's Office

19 - Off-Campus Outpatient Hospital
22 - Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic
81 - Independent Laboratory

HCV screening claims submitted without one of the POS codes noted above will be denied.

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

(Rev. 13680; Issued: 03-26-26; Effective: 10-01-25; Implementation: 07-06-26)

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 *or G0567 (effective 6/27/24)*:

- 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 G047 *or G0567 (effective 6/27/24)*, 2, 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-10 diagnosis code Z72.89, other problems related to lifestyle, and ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated:

  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 *or G0567 (effective 6/27/24)*, 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-10 diagnosis code Z72.89, and ICD-10 diagnosis code F19.20, 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 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, if beneficiary born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 or F19.20 or Z11.59:

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. 13680; Issued: 03-26-26; Effective: 10-01-25; Implementation: 07-06-26)

The common working file (CWF) shall apply the following frequency limitations to HCV screening, HCPCS G0472 *or G0567 (effective 6/27/24)*:

One initial HCV screening, HCPCS G0472 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, 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 *or G0567 (effective 6/27/24)*, is not a covered service for beneficiaries born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 and/or F19.20 and/or Z11.59 ICD-10 diagnosis code.