DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Change Request (CR) #: CR9200

Effective Date: June 2, 2014

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.

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

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.

Provider Action Needed

Change Request (CR) 9200 informs providers that beneficiaries born prior to 1945 or after 1965 with no risk factors for HCV are not eligible for HCV screening benefits as described in CR8871, Transmittal 3215, dated March 11, 2015. Make sure that your billing staffs are aware of these changes.

Background

Effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) covers screening for 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 CR8871.You may want to review the related MLN Matters® article **MM8871** for additional claims processing instructions.

As indicated in CR8871, and replicated in CR9200 for ease of reference only, CMS covers screening for HCV with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices), 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.

Key Points

- 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.
- Beneficiaries born prior to 1945 or after 1965 with no risk factors are not eligible for this benefit.
- 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" (when ICD-10 is implemented ICD-10 diagnosis code Z72.89, "other problems related to lifestyle") is required in addition to HCPCS G0472.

- 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 diagnosis code 304.91, "unspecified drug dependence continuous"/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.
- HCV screening, HCPCS code G0472, is a technical service only and there is no professional fee.
- CR9200 also removes the following types of bill (TOBs) as valid TOBs for HCV screening services:
  - * RHC, TOB 71X;
  - * FQHC, TOB 77X; and

  ** CAH Method II, professional services, TOB 85X when submitted with revenue code 096X, 097X, or 098X. * NOTE: While RHCs and FQHCs cannot bill for HCV screening services, this does not prevent HCV screening services from being provided to patients at RHCs and FQHCs.

  ** NOTE: CAHs, TOB 85X, are valid facilities for HCV screening services. CR9200 removes the professional payment to CAHs for HCV screening.
- MACs will line-item deny claims for HCV screening, HCPCS G0472, for beneficiaries born prior to 1945 and after 1965 who are not high risk 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.; and
  - Group Code CO – assigning financial liability to the provider.

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.

Additional Information

The official instruction, CR9200 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3285CP.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-Network-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.
August 10, 2015	The article was revised to make clarifications regarding HCV services in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals.