CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3831	**Date: August 4, 2017**
	Change Request 9859

Transmittal 3804, dated June 29, 2017, is being rescinded and replaced by Transmittal 3831, dated, August 4, 2017 to provide clarification in Pub. 100-04 Business Requirement 9859.04.13 and to revise the note. The new note will read, "Payment for HBV is not separately payable for ESRD facilities (72X TOB) unless reported with Modifier AY." The corresponding update to note is being made in the Pub. 100-04 claims processing manual. All other information remains the same.

SUBJECT: Screening for Hepatitis B Virus (HBV) Infection

I. SUMMARY OF CHANGES: CMS has determined that effective September 28, 2016, screening for HBV infection will be covered 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 (CLIA) regulations.

EFFECTIVE DATE: September 28, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation

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/Table of Contents
N	18/230/Screening for Hepatitis B Virus (HBV)
N	18/230.1/Institutional Billing Requirements
N	18/230.2/Professional Billing Requirements
N	18/230.3/Diagnosis Code Reporting Requirements
N	18/230.4/Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

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: 3831	Date: August 4, 2017	Change Request: 9859

Transmittal 3804, dated June 29, 2017, is being rescinded and replaced by Transmittal 3831, dated, August 4, 2017 to provide clarification in Pub. 100-04 Business Requirement 9859.04.13 and to revise the note. The new note will read, "Payment for HBV is not separately payable for ESRD facilities (72X TOB) unless reported with Modifier AY." The corresponding update to note is being made in the Pub. 100-04 claims processing manual. All other information remains the same.

SUBJECT: Screening for Hepatitis B Virus (HBV) Infection

EFFECTIVE DATE: September 28, 2016
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I. GENERAL INFORMATION

A. Background: Pursuant to §1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

(1)Reasonable and necessary for the prevention or early detection of illness or disability.

(2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).

(3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for screening for hepatitis B Virus (HBV) infection and determined that the criteria listed above were met. Therefore, effective November 8, 2011, CMS covered screening for HBV infection only for pregnant women at the first prenatal visit when the diagnosis of pregnancy is known and then rescreening at time of delivery for those with new or continuing risk factors. Screening for HBV infection was not covered for any other populations.

B. Policy: The USPSTF updated its recommendations regarding HBV screening. Therefore, CMS has determined that the evidence is adequate to conclude that screening for HBV infection, consistent with the grade A and grade B recommendations by the USPSTF, is reasonable and necessary for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective September 28, 2016, CMS will cover screening for HBV infection 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 (CLIA) 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 screening test is covered for asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. "High risk" is defined as persons born in countries and regions with a high prevalence of HBV infection (i.e., ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (i.e., ≥ 8%), HIV-positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually only for beneficiaries with continued

high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who do not receive hepatitis B vaccination.

A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

The determination of "high risk for HBV" 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: There are no changes to the policy in CR 7610 for the requirements related to HBV screening for pregnant women. Beginning the effective date of this policy, contractors will file their HBV claims according to the instructions here in NCD 210.6

Note for ESRD: There are no changes to the policy for ESRD, to ensure the appropriate ICD-10 code is used, please note effective on or after September 28, 2016 when submitted with G0499 – “HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries” and ICD-10 diagnosis code N18.6, End Stage Renal Disease, all of the preceding requirements shall be bypassed and the claim shall be allowed to pay, no matter what other ICD-10 diagnosis codes may appear on the claim.

Note on Timely Filing: Since the implementation of the policies described above and business requirements listed below was delayed by CMS until October 2, 2017, there may be requests to the MACs from suppliers seeking exceptions to the 1 calendar year time limit for filing claims for services furnished September 28 through October 1, 2016. MACs are reminded that the requirements for granting an exception to the 1 calendar year time limit for filing claims are in IOM Publication 100-04, Chapter 1, section 70.7. MACs have the authority to grant exceptions to the 1 calendar year time limit for filing claims if these requirements are met.

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	
9859 - 04.1	Effective for claims with dates of service on and after September 28, 2016, contractors shall recognize new HCPCS code G0499- Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBsAg) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBsAg (anti-HBs) and hepatitis B core antigen (anti-HBc)	X	X							IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Short Descriptor: HepB screen high risk indiv TOS=5 NOTE: HCPCS code G0499 will appear in the January 1, 2018, Clinical Laboratory Fee Schedule (CLFS), in the January 1, 2017, Integrated Outpatient Code Editor (IOCE), and in the January 1, 2017, Medicare Physician Fee Schedule (MPFS) with indicator 'X'. HCPCS code G0499 will be effective retroactive to September 28, 2016 in the IOCE. NOTE: Refer to Pub. 100-03, Medicare NCD Manual, Chapter 1, Section 210.6 for coverage policy, and Pub. 100-04, Claims Processing Manual, Chapter 18, Section 170 for claims processing instructions.									
9859 - 04.1.1	Contractors shall add HCPCS G0499 short description to the MSN file. NOTE: Part A MACs shall load the long description to their MSN file as they currently do.	X	X							
9859 - 04.2	Contractors shall apply contractor pricing to claim lines containing HCPCS code G0499 with dates of service September 28, 2016 through December 31, 2017. Deductible and coinsurance do not apply.	X	X							
9859 - 04.2.1	Contractors shall manually add HCPCS G0499 to the 2016 MPFSDB with the same status and policy indicators as the 2017 MPFSDB record.		X							
9859 - 04.3	Contractors shall not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS G0499, HepB screen high risk indiv.	X	X			X				
9859 - 04.4	Effective for claims with dates of service on or after September 28, 2016, contractors shall deny line items on claims containing HCPCS G0499, HepB screen high risk indiv for asymptomatic					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	non-pregnant beneficiaries, when reported more than once per annum (at least 11 full months must elapse from the date of the last screening), or if the beneficiary's claim history shows claim lines containing CPT codes 87340, or 87341, or 86704, or 86706 along with Z11.59 and one of the pregnancy diagnosis codes listed in BR 9859 – 04.9 which was submitted in the previous 11 full months.									
9859 - 04.4.1	When denying a line-item on claim per requirement 9859-04.4, contractors shall 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 occurrence code 32 with or without a GA modifier or a claim-line 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 line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present).	X	X							
9859 - 04.4.2	(Continuation of 9859-04.4.1.) (Part A only) MSN 15.19: "Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 (1800-633-4227). MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión." 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.									
9859 - 04.5	Effective for claims with dates of service on or after September 28, 2016, contractors shall pay line items on claims containing HCPCS code G0499, HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries, for their initial screening, when both ICD-10 codes (Z72.89 AND Z11.59) are present on the claim. Z72.89 - Other problems related to life style----		X			X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Z11.59 - Encounter for screening for other viral disease.									
9859 - 04.5.1	Effective for claims with dates of service on or after September 28, 2016, contractors shall deny line items on claims containing HCPCS code G0499, HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries, for their initial screening, when both ICD-10 codes (Z72.89 AND Z11.59) are not present on the claim.		X			X	X		X	
9859 - 04.5.2	When denying a line-item on a claim per requirement 9859-04.5.1, contractors shall 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 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 (Contractual Obligation).	X	X							
9859 - 04.5.3	(Continuation of 9859-04.5.2) (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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión." 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.									
9859 - 04.5.4	Effective for claims with dates of service on or after September 28, 2016, contractors shall deny line items on claims containing HCPCS code G0499, HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries, for their initial screening, when any of the following ICD-10 codes listed below are present on the claim. Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester O09.91 Supervision of high risk pregnancy, unspecified, first trimester O09.92 Supervision of high risk pregnancy, unspecified, second trimester O09.93 Supervision of high risk pregnancy, unspecified, third trimester									
9859 - 04.5.5	When denying a line-item on a claim per requirement 9859-04.5.4, contractors shall use the following messages: CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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 (Contractual Obligation).									
9859 - 04.5.6	(Continuation of 9859-04.5.5) (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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
9859 - 04.6	Effective for claims with dates of service on or after September 28, 2016, contractors shall pay line items on claims containing HCPCS code G0499, HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries, for subsequent screenings of high-risk patients (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) when ICD-10 dx code Z11.59 and one of the specific high risk diagnosis codes below is listed: F11.10-F11.99 F13.10-F13.99 F14.10-F14.99 F15.10-F15.99 Z20.2 Z20.5 Z72.52 Z72.53		X			X	X		X	
9859 - 04.6.1	When denying a line-item on a claim per requirement 9859-04.6, contractors shall use the following messages:	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 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 (Contractual Obligation).									
9859 - 04.6.2	Continuation of 9859- 04.6.1) (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 210.6 were used when we made this decision."	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión." 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									
9859 - 04.6.3	CWF shall search history to determine if a claim is submitted with the requirements indicated in 04.5 is posted within the last 12 months. Contractors and shared systems shall ensure that claims meeting the requirements of BR 9859-04.6 (a "subsequent HBV screening test for non-pregnant, high-risk beneficiary") are denied when a claim for the same beneficiary meeting the requirements in BR 9859-04.5 (an "initial HBV screening test for non-pregnant, high-risk beneficiary") has not been adjudicated to a final payment status at any time in the past.	X	X			X			X	
9859 - 04.6.3.1	When denying a line-item on a claim per requirement 9859-04.6.3, contractors shall use the following messages: CARC B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. 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 on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD."	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO (Contractual Obligation).									
9859 - 04.6.3.2	(Continuation of 9859-04.6.3.1) MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances. Spanish Version - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias. (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 210.6 were used when we made this decision.” Spanish Version – “Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión.” NOTE: Due to system requirement, FISS has combined messages 15.19 and 15.20 so that,	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	when used for the same line item, both messages will appear on the same MSN.									
9859 - 04.7	Contractors shall end-date the HBV screening editing established for NCD 210.10 and implemented in CR 7610, Transmittal 2476 issued May 23, 2012 for dates of service prior to September 28, 2016.	X	X			X	X		X	
9859 - 04.8	Effective with date of service on or after September 28, 2016, any Hepatitis B (CPT 87340, 87341, 86704, 86706) editing for pregnant beneficiaries built into NCD 210.10 under CR 7610 shall be programmed into the editing required via instructions below (BR 9859-04.9 and forward) for pregnant beneficiaries under NCD 210.6.	X	X			X	X		X	
9859 - 04.9	Contractors shall allow one (1) screening test per pregnancy for hepatitis B in pregnant women when the screening is billed with the one of the CPT codes 87340, 87341, 86704, 86706) and the following: Z11.59 - Encounter for screening for other viral disease. and one of the following: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester		X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester O09.91 Supervision of high risk pregnancy, unspecified, first trimester O09.92 Supervision of high risk pregnancy, unspecified, second trimester O09.93 Supervision of high risk pregnancy, unspecified, third trimester									
9859 - 04.9.1	CWF shall create an edit to allow no more than one (1) hepatitis B screening test per pregnancy beginning with the date of the 1st test containing any of the codes for hepatitis B contained in 9859-04.9, ICD-10 code Z11.59, and one of the diagnosis codes below: Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first trimester					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester O09.91 Supervision of high risk pregnancy, unspecified, first trimester O09.92 Supervision of high risk pregnancy, unspecified, second trimester O09.93 Supervision of high risk pregnancy, unspecified, third trimester NOTE: CWF shall allow this edit to be overridable.									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9859 - 04.9.2	Contractors shall allow two (2) screening tests per pregnancy for hepatitis B in pregnant women who are at increased risk for STIs when the screening is billed with the following: Z11.59 - Encounter for screening for other viral disease, and one of the following: Z34.00Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester O09.91 Supervision of high risk pregnancy, unspecified, first trimester O09.92 Supervision of high risk pregnancy, unspecified, second trimester O09.93 Supervision of high risk pregnancy, unspecified, third trimester									
9859 - 04.9.2.1	CWF shall create an edit to allow no more than two (2) hepatitis B screening tests per pregnancy beginning with the date of the 1st test containing any of the codes for hepatitis B contained in 9859- 04.9 ICD-10 code Z11.59, and one of the ICD-10 diagnosis codes listed above. **NOTE:** The 2nd test must be billed with Z11.59 - Encounter for screening for other viral disease and, and Z72.89, other problems related to lifestyle, and one of the pregnancy diagnosis codes listed above. The initial test may be billed with or without Z72.89. NOTE: CWF shall allow this edit to be overridable.					X			X	
9859 - 04.9.3	Contractors shall deny line items submitted for hepatitis B screening that exceed the coverage frequency limitations indicated in 9859-04.9–9.2.1 with the following: CARC: 119 – "Benefit maximum for this period or occurrence has been reached" RARC N362: "The number of days or units of service exceeds our acceptable maximum." RARC N386 – "This decision was based on a National Coverage Determination (NCD). An	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 (Contractual Obligation) assigning financial liability to the provider (if a claim is received with occurrence code 32 with or without a GZ modifier indicating no signed ABN is on file). 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 and occurrence code 32 is not present).									
9859 - 04.9.3.1	(Continuation of 9859-04.9.3) (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).	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."									
9859 - 04.9.4	When denying a line-item on a claim when submitted with inappropriate ICD-10 diagnosis codes or when denying line items billed with CPT codes listed and Z11.59 but without one of the pregnancy diagnostic codes listed in BR 9859- 04.9 through 04.9.2 as per requirement 9859-04.9- 9.2.1, contractors shall 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 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 (Contractual Obligation).	X	X							
9859 - 04.9.4.1	(Continuation of 9859- 04.9.4) (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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión." 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.									
9859 - 04.10	Contractors shall pay for HBV screening, HCPCS G0499, 87340, 87341, 86704, 86706 only when services are provided at the followings Place of Service (POS): 11- Physician's Office 19 – Off Campus Outpatient Hospital 22 – On-Campus Outpatient Hospital		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	49 - Independent Clinic 71 - State or Local Public Health Clinic 81 – Independent Laboratory									
9859 - 04.10.1	When denying claim lines for HBV screening because the POS criteria in 9859.04-10 has not been met, use the following messages: 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. Group Code: CO (Contractual Obligation). 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."		X							
9859 - 04.11	Contractors shall identify the following institutional claims as facility fee claims for HBV screening, HCPCS G0499 , 87340, 87341, 86704, or 86706: Type of Bill (TOB) 13X Hospital Outpatient departments TOB 14X non-patient laboratory specimen					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	TOB 85X Critical Access Hospitals (CAHs) when the revenue code is not 096X, 097X, and 098X. TOB 72X End Stage Renal Disease (ESRD) when submitting code G0499 with diagnosis code N18.6.									
9859 - 04.12	Contractors shall apply contractor pricing for HCPCS G0499, on institutional claims submitted on types of bill (TOBs) 13X,14X, 72X with diagnosis code N18.6, and 85X for claims with dates of service on or after September 28, 2016 through December 31, 2017. NOTE: Deductible and coinsurance do not apply.	X								
9859 - 04.13	Effective for line-items with dates of service on and after January 1, 2018, contractors shall pay for HBV screening, HCPCS G0499, 87340, 87341, 86704, or 86706, on institutional claims in hospital outpatient departments (TOB 13X) based on the Outpatient Prospective Payment System, non-patient-laboratory specimen (TOB 14X) based on lab fee schedule, ESRD facilities (TOB 72X with code G0499 and diagnosis code N18.6) based on ESRD PPS, and in CAHs (TOB 85X) based on reasonable cost. NOTE: Payment for HBV is not separately payable for ESRD facilities (72X TOB) unless reported with Modifier AY.	X				X				
9859 - 04.14	Contractors shall deny line-items on claims for HBV screening, HCPCS G0499, 87340, 87341, 86704, or 86706 when submitted on a TOB other than 13X, 14X, 72X (with code G0499 and diagnosis code N18.6), or 85X using the following messages:	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 assigning financial liability to the provider.									
9859 - 04.15	Effective for dates of service on or after September 28, 2016, MCS shall create an edit to ensure that contractors pay for HBV screenings when reported with the diagnosis codes in 9859.-04.5, 04.6, 04.9-9.2.1, only when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes on the provider's enrollment record: 01 – General Practice 08 – Family Practice 11 – Internal Medicine 16 – Obstetrics/Gynecology 37 – Pediatric Medicine 38 – Geriatric Medicine		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	42 – Certified Nurse Midwife 50 – Nurse Practitioner 89 – Certified Clinical Nurse Specialist 97 – Physician Assistant									
9859 - 04.16	Contractors shall deny claim line items for HBV when ordered by any provider specialty types other than those listed in 9859.-04.15 with the following: 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 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." MSN 21.18: "This item or service is not covered when performed or ordered by this provider." Spanish Version: "Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor." MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión." Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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). NOTE: For modifier GZ, use CARC 50 and MSN 8.81									
9859 - 04.17	CWF shall calculate a next eligible date for HCPCS G0499 for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules NOTE: The calculation for preventive services next eligible date shall parallel claims processing.								X	
9859 - 04.18	The next eligible dates shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).	X				X			X	MBD, NGD
9859 - 04.19	When there is no next eligible date, the CWF provider query screens shall display this information in the date field to indicate why there is not a next eligible date.								X	
9859 - 04.20	Any change to beneficiary master data or claims data that would result in a change to any next eligible date shall result in an update to the beneficiary's next eligible date.								X	
9859 - 04.21	The Multi-Carrier System Desktop Tool (MCSDT) shall display HCPCS G0499 on a separate screen and in a format equivalent to the		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CWF HIMR screen.									
9859 - 04.22	Contractors shall hold institutional claims containing HCPCS code G0499 with dates of service September 28, 2016 thru December 31, 2016. Contractors shall release these claims upon implementation of the January 2017 IOCE. When releasing claims contractor shall enter condition code 15.	X								
9859 - 04.23	Contractors shall not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but contractors may adjust claims that are brought to their attention.	X	X							
9859 - 04.24	Effective for claims with dates of service on or after September 28, 2016 submitted with G0499 – "HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries" and ICD-10 diagnosis code N18.6, End Stage Renal Disease, all of the preceding requirements shall be bypassed and the claim shall be allowed to pay, no matter what other ICD-10 diagnosis codes may appear on the claim.	X	X			X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9859 - 04.25	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	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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.					

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Leah Cromwell, 410-786-2243 or Leah.Cromwell1@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) , Wendy Knarr, 410-786-0843 or Wendy.Knarr@cms.hhs.gov (Supplier Claims) , William Ruiz, 410-786-9283 or William.Ruiz@cms.hhs.gov (Institutional Claims) , Thomas Dorsey, 410-786-7434 or Thomas.Dorsey@cms.hhs.gov (Practitioner Claims)

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

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev.3831, 08-04-17)

230 – Screening for Hepatitis B Virus (HBV)

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

Effective for services furnished on or after September 28, 2016, an initial screening for hepatitis B virus infection (HBV) is covered for asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. "High risk" is defined as persons born in countries and regions with high prevalence of HBV infection (i.e., ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (i.e., ≥ 8%), HIV-positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection.

In addition, CMS has determined that repeated screening would be appropriate annually only for beneficiaries with continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who do not receive hepatitis B vaccination.

A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results. See section 170 of this chapter for coverage and billing instructions for pregnant beneficiaries.

Effective for claims with dates of service on or after September 28, 2016, the claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT codes:

- *HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499*
- *HBV screening for pregnant women – CPT codes 86704, 86706, 87340 and 87341*

A. Frequency

HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk (HCPCS code G0499)

- *A single, one-time screening test is covered for asymptomatic, non pregnant adolescents and adults who do meet the high risk definition above.*
- *Repeat screening for high risk persons is covered annually only for persons who have continued high risk who do not receive hepatitis B vaccination .*

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

Note for ESRD: Effective for claims with dates of service on or after September 28, 2016 submitted with G0499 – "HepB screen high risk indiv, for asymptomatic non-pregnant beneficiaries" and ICD-10 diagnosis code N18.6, End Stage Renal Disease, all of the preceding requirements shall be bypassed and the claim shall be allowed to pay, no matter what other ICD-10 diagnosis codes may appear on the claim.

HBV screening for pregnant women (CPT codes 86704, 86706, 87340 and 87341)

- *One occurrence per pregnancy of screening for HBV in pregnant women, and*

- *One additional occurrence per pregnancy of screening for HBV in pregnant women who are at continued risk*

B. Determination of High Risk for Hepatitis B Disease

The determination of "high risk for HBV" 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: See Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual §210.6 for complete coverage guidelines.

230.1 – Institutional Billing Requirements

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

Effective for claims with dates of service on or after September 28, 2016, providers may use the following types of bill (TOBs) when submitting claims for HBV screening, HCPCS G0499, 86704, 86706, 87340, and 87341: 13X, 14X, 72X, and 85X. Deductible and coinsurance do not apply. 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*
- *Non-patient laboratory specimen – TOB 14X – based on laboratory fee schedule*
- *End Stage Renal Disease facilities (ESRDs) – TOB 72X – based on ESRD PPS when submitted with code G0499 and diagnosis code N18.6. HBV is not separately payable for (ESRD TOB 72X) unless reported with Modifier AY.*
- *Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost when the revenue code is not 096X, 097X, and 098X*

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

***NOTE**: Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0499, and CPT codes 86704, 86706, 87340, and 87341.*

***NOTE:** Medicare Administrative Contractors shall contractor-price HBV screening claims, HCPCS G0499, with dates of service September 28, 2016 through December 31, 2017.*

230.2 – Professional Billing Requirements

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, CPT codes 86704, 86706, 87340, 87341, and HCPCS G0499, 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

Claims ordered by providers other than the specialty types noted above will be denied.

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, 86704, 86706, 87340, 87341, and G0499, only when submitted with one of the following place of service (POS) codes:

11 – Physician's Office
19- Off Campus Outpatient Hospital
22 – On Campus Outpatient Hospital
49 – Independent Clinic
71 – State or Local Public Health Clinic
81-Independent Laboratory
Claims submitted without one of the POS codes noted above will be denied.

***NOTE**: Beneficiary coinsurance and deductibles do not apply to claim lines containing CPT codes 86704, 86706, 87340, 87341, and HCPCS G0499.*

***NOTE:** Medicare Administrative Contractors shall contractor-price HBV screening claims, HCPCS G0499, with dates of service September 28, 2016 through December 31, 2017.*

230.3 – Diagnosis Code Reporting Requirements

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, HCPCS G0499, only when services are reported with both of the following diagnosis codes denoting high risk:

- *Z11.59 Encounter for screening for other viral disease*
  and
- *Z72.89 Other Problems related to life style*

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening, HCPCS G0499, for subsequent visits only when services are reported with one of the following diagnosis code:

- *Z11.59, and one of the high risk codes below*
- *F11.10-F11.99*
- *F13.10-F13.99*
- *F14.10-F14.99*
- *F15.10-F15.99*

- *Z20.2*
- *Z20.5*
- *Z72.52*
- *Z72.53*

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- *Z11.59 - Encounter for screening for other viral diseases,* ***and*** *one of the following*
- *Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester,*
- *Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester,*
- *Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester,*
- *O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester.*

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT codes 86704, 86706, 87340 and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- *Z11.59 - Encounter for screening for other viral diseases, and*
- *Z72.89 - Other problems related to lifestyle,*
- ***and*** *also one of the following:*

Code	***Description***
Z34.00	*Encounter for supervision of normal first pregnancy, unspecified trimester*
Z34.01	*Encounter for supervision of normal first pregnancy, first trimester*
Z34.02	*Encounter for supervision of normal first pregnancy, second trimester*
Z34.03	*Encounter for supervision of normal first pregnancy, third trimester*
Z34.80	*Encounter for supervision of other normal pregnancy, unspecified trimester*
Z34.81	*Encounter for supervision of other normal pregnancy, first trimester*
Z34.82	*Encounter for supervision of other normal pregnancy, second trimester*
Z34.83	*Encounter for supervision of other normal pregnancy, third trimester*
Z34.90	*Encounter for supervision of normal pregnancy, unspecified, unspecified trimester*
Z34.91	*Encounter for supervision of normal pregnancy, unspecified, first trimester*
Z34.92	*Encounter for supervision of normal pregnancy, unspecified, second trimester*
Z34.93	*Encounter for supervision of normal pregnancy, unspecified, third trimester*
O09.90	*Supervision of high risk pregnancy, unspecified, unspecified trimester*
O09.91	*Supervision of high risk pregnancy, unspecified, first trimester*
O09.92	*Supervision of high risk pregnancy, unspecified, second trimester*
O09.93	*Supervision of high risk pregnancy, unspecified, third trimester*

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

(Rev. 3831, Issued: 08-04-17, Effective: 09-28-16, Implementation: 10- 02- 17, October 2, 2017 - analysis and design; January 2, 2018 - testing and implementation)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when rejecting payment for HBV screening:

- *Rejecting services submitted on a TOB other than 13X, 14X, 72X, 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

- *Denying services where previous HBV screening, HCPCS G0499, is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary's claim history shows claim lines containing CPT codes 86704, 86706, 87340 and 87341 submitted in the previous 11 full months 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.
  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 occurrence code 32 with or without GA modifier or a claim –line 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 line-item is received with a GZ modifier indicating no signed ABN is on file and occurrence code 32 is not present).
  (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 1-800MEDICARE (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 (1800-633-4227).
  MSN 15.20: "The following policies NCD 210.6 were used when we made this decision."
  Spanish Version – "Las siguientes políticas NCD 210.6fueron utilizadas cuando se tomó esta decisión."
  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.

  - *Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim use:*

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.

(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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

Group Code: CO (Contractual Obligation)

***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.*

- *Denying services for HBV screening, HCPCS G0499, for subsequent visits, when ICD-10 diagnosis code Z11.59, and one of the following high risk codes ,F11.10 – F11.99, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim use:*

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.

(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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

Group Code: CO (Contractual Obligation)

***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.*

- *Denying claim lines for HBV screening, HCPCS G0499, without the appropriate POS code use:*

  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.

  Group Code: CO (Contractual Obligation)

  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."

  - *Denying claim lines for HBV screening, HCPCS G0499, that are not submitted from the appropriate provider specialties use:*

  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 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."

  MSN 21.18 - This item or service is not covered when performed or ordered by this provider.

  Spanish Version: "Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor."

  MSN 15.20: "The following policies NCD 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

  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 line-item is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- *When denying services where previous HBV screening, HCPCS 86704, 86706, 87340 or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, use:*

  CARC 119: "Benefit maximum for this time period or occurrence has been reached."
  RARC N362: "The number of days or units of service exceeds our acceptable maximum."
  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."

(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).

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 and occurrence code 32 is not present)

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with occurrence code 32 with or without a GZ modifier indicating no signed ABN is on file).

- *Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:*

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 (Contractual Obligation)

(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 210.6 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

***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.*

- *Denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:*

CARC B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. 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 when denying a line-item on a claim per requirement 9859-04.6.3, contractors shall use the following messages:

Group Code: CO (Contractual Obligation).

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.

Spanish Version - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.

(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 210.6 were used when we made this decision."
Spanish Version – "Las siguientes políticas NCD 210.6 fueron utilizadas cuando se tomó esta decisión."

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.