CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3835	**Date: August 16, 2017**
	Change Request 9980

Transmittal 3778, dated May 24 2017 is being rescinded and replaced by Transmittal 3835, dated, August 16, 2017 to remove procedure code 80081 from BR 9980.17 so that the MCSDT screen will mirror the PRVN HIMR screen. All other information remains the same.

SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that they shall recognize the specified HCPCS codes for services related to the **Screening for the Human Immunodeficiency Virus (HIV) Infection.**

EFFECTIVE DATE: April 13, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

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	18/130.1/ Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests
R	18/130.2/Billing Requirements
R	18/130.3/ Payment Method
R	18/130.4/Types of Bill (TOBs) and Revenue Codes
R	18/130.5/Diagnosis Code Reporting
R	18/130.6/Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

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: 3835	Date: August 16, 2017	Change Request: 9980

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SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

EFFECTIVE DATE: April 13, 2015
**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: CMS issued CR 9403 (transmittal 3461) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3461CP.pdf, effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013 which stated that screening for HIV infection for all individuals between the ages of 15 and 65 years, as recommended with a Grade of A by the USPSTF, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Additionally, individuals younger than 15 and older than 65 who are at perceived risk are eligible for screening. The recommendations provide further guidelines for screening various age groups based on risk of infection as well as for pregnant women and this specific criteria can be found in NCD section 210.7.

B. Policy: Effective for claims with dates of service on or after April 13, 2015, contractors shall recognize the following HCPCS codes for claims processed on or after October 2, 2017: G0432, G0433 and G0435. Testing frequency and other functions for these codes shall be the same as those listed in CR9403.

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	
9980.1	Effective for claims with dates of service on or after April 13, 2015, contractors shall include the following HCPCS codes for HIV screening for claims that process on or after October 2, 2017. Apply the same editing logic as previously implemented in CR 9403 for G0475.	X	X						X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	G0432 - Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody,HIV-1 or HIV-2, screening, and, G0435 - Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening. NOTE: Co-insurance and deductible do not apply.									
9980.2	Effective for claims with dates of service on or after April 13, 2015, contractors shall no longer apply frequency edits from CR 6786-SCREENING FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) and disable the following edits 7561 and 7562.		X			X			X	
9980.3	Contractor shall calculate the next eligible date for HIV Screening to include HCPCS code G0432, G0433 and G0435 to be included with G0475 and based on effective date of April 13, 2015.								X	
9980.3.1	HCPCS on the HUQA screen shall be combined for the same service for the Next Eligible Date.	X				X			X	
9980.3.2	Contractors will need to perform testing of HUQA changes described in BR 9980.3.1.	X								
9980.4	The next eligible date shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.					X			X	MBD, NGD
9980.5	When there is no next eligible date, the CWF provider query screens shall display this information in the date field to indicate why there								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	is not a next eligible date.									
9980.6	Contractor shall create a new consistency line level edit to reject (CWF) or deny (MACs) for dates of service on or after April 13, 2015:When the incoming HUOP or HUBC claim having the HIV screening HCPCS code G0475, G0432, G0433' or G0435 is submitted without the required HIV Primary Diagnosis Codes: ICD-10: Z11.4 --OR-- When the incoming HUOP or HUBC claim having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis codes is not present: Secondary Diagnosis Codes: ICD-10: 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, O09.91O09.92, O09.93	X	X			X			X	
9980.6.1	Contractor shall deny a line-item on the claim per requirement 9980.6 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. 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) (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"									
9980.6.1.1	**(Continuation to 9980.6.1)** 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 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 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.	X	X							
9980.6.1.2	Contractor shall create new 59XXX reason codes for business requirements 9980.6.1 CWF edits specified as denials to allow medical savings to be captured for the denials. The CWF reason code will be converted to the associated					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	59XXX reason code prior to adjudicating the line.									
9980.6.2	Contractor shall disable Utilization edit 5321 to be replaced with new consistency edit addressed in BR 9980.6. Current Error Message for 5321 - A HIV Screening with HCPCS code G0475 is present without diagnosis code ICD-9 V73.89/ICD-10 Z11.4 for a beneficiary between the ages of 15 through 65 without regard to risk.	X	X			X			X	
9980.6.3	Contractor shall modify Utilization Edit 5322 to require High Risk Diagnosis and at least one of the Pregnancy Diagnosis for female Beneficiary who is less than 15 or greater than 65. Current Error Message for 5322 - A HIV screening with HCPCS code G0475 is present without diagnosis code ICD-10 - Z11.4 - And - Secondary diagnosis ICD-10 - Z72.51, Z72.89, Z72.52, Z72.53 for a beneficiary less than 15 or greater than 65 years of age with an increased risk of 'HIV' infection. CWF will include HIV Screening HCPCS G0432, G0433 and G0435 with Utilization edit 5322 - The Secondary Diagnosis Codes indicating the Age Related High Risk are: ICD-10 - Z72.51, Z72.89, Z72.52, Z72.53		X						X	
9980.7	Contractor shall create a new consistency edit to reject (CWF) or deny (B/MACs), when the incoming HUOP or HUBC claim having the CPT HCPCS code 80081 is submitted with one of the following required HIV primary diagnosis codes:		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	ICD-10: Z11.4 -And- None of the following secondary diagnosis codes denoting pregnancy are present. ICD-10: 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, O09.93									
9980.7.1	When denying a line-item on the claim per requirement 9980.7 Contractors shall use the following messages: CARC 11 - This diagnosis is inconsistent with the procedure. 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".	X	X							
9980.7.1.1	**(Continuation to 9980.7.1)** Spanish Version - Las Determinaciones Locales de Cobertura (LCDs en inglés) le ayudan a decidir	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 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.									
9980.7.1.2	Contractor shall create new 59XXX reason codes for business requirements 9980.7.1 CWF edits specified as denials to allow medical savings to be captured for the denials. The CWF reason code will be converted to the associated 59XXX reason code prior to adjudicating the line.					X				
9980.8	Contractor shall create a new consistency line level edit to reject (CWF), or deny (MACs), when the incoming HUOP or HUBC claim having either the HIV HCPCS codes G0475, G0432, G0433, G0435 or the CPT HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates 'Male'. The secondary diagnosis codes indicating pregnancy are: ICD-10: 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, O09.93	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9980.8.1	When denying a line-item on the claim per requirement 9980.8 Contractors shall use the following messages: CARC 7 - The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 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".	X	X							
9980.8.1.1	**(Continuation to 9980.8.1)** 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 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 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.									
9980.8.1.2	Contractor shall create new 59XXX reason codes for business requirements 9980.8.1 CWF edits specified as denials to allow medical savings to be captured for the denials. The CWF reason code will be converted to the associated 59XXX reason code prior to adjudicating the line.					X				
9980.9	Contractor shall consolidate Utilization edit codes 5324 and 5325 into one Utilization Edit, retaining the 5325 edit code. Current Error Message for 5325 - A HIV Screening for a Beneficiary less than 15 or greater than 65 years of age is within 11 full months of a posted HIV Screening on the HIVS Auxiliary file. CWF shall include HIV Screening HCPCS G0432, G0433 and G0435 with Utilization edit 5325.		X			X			X	
9980.9.1	Contractor shall disable Utilization edit 5324 Current Error Message for 5324 - A HIV Screening for a Beneficiary between the ages of 15 through 65 is within 11 full months of a posted HIV Screening on the HIVS Auxiliary file.		X			X			X	
9980.10	Contractor shall disable Utilization edit 5323 Current Error Message for 5323 - A HIV Screening with HCPCS code G0475 is present without diagnosis code: ICD-10: 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, O09.93		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	for a pregnant female Beneficiary.									
9980.11	Contractor shall modify Utilization Edit 5326 to include HCPCS G0432, G0433 and G0435 for HIV Pregnancy that checks for the three screening tests within the full 9 months. Current Error Message for 5326 - A HIV Screening is within 9 months of three HIV screening posted on the HIVS Auxiliary file.		X			X			X	
9980.12	Contractor shall create a consistency edit to reject (CWF), or deny (B/MACs), line-items with POS other than 11 (Office) or 81 (Independent Lab for the HIV screenings HCPCS G0475, G0432, G0433 and 'G0435' effective with dates of service on or after April 13, 2015.		X						X	
9980.12.1	When denying a line-item on the claim per requirement 9980.12, Contractors shall use the following messages: CARC 171 – Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N428 -Not covered when performed in this place of service. Group Code: CO (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							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(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".									
9980.12.2	**(Continuation to 9980.12.1)** 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 210.7 were used when we made this decision." Spanish Version – "Las siguientes políticas NCD 210.7 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.		X							
9980.13	Medicare Contractors shall ensure HIV screening HCPCS G0475, G0432, G0433 and G0435 are only allowed on type of bill (TOB) 12X, 13X, 14X, 22X, 23X and 85X.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9980.14	Contractor shall end date reason codes 31738, 31739, 59160 and 59161 for dates of service after 04/13/15.					X				
9980.15	FISS shall update the DDE eligibility inquiry to display the next available date for HCPCS G0432, G0433, G0435, G0475 and 80081 when returned from CWF on the HUQA response.					X				
9980.16	Contractors shall turn off edit 049L for HCPCS G0432, G0433, and G0435.		X				X			
9980.17	The Multi-Carrier System Desktop Tool (MCSDT) shall display HIV Screening HCPCS G0432, G0433, G0435, and G0475 in a format equivalent to the CWF HIMR screen(s).		X				X			
9980.18	Contractors shall not search for these claims but may adjust these claims that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9980.19	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: 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): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage) , Wendy Knarr, 410-786-0843 or wendy.knarr@cms.hhs.gov (Supplier Claims) , Yvette Cousar, 410-786-2160 or Yvette.Cousar@cms.hhs.gov (Practitioner Claims) , Shauntari Cheely, 410-786-1818 or Shauntari.Cheely@cms.hhs.gov (Institutional Claims) , Stuart Caplan, 410-786-8564 or stuart.caplan@cms.hhs.gov (Coverage) , Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocatosimons@cms.hhs.gov (Coverage)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

130 - Human Immunodeficiency Virus (HIV) Screening Tests
(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

130.1 - Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests
(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Effective for claims with dates of service on and after December 8, 2009, implemented with the April 5, 2010, IOCE, the following HCPCS codes are to be billed for human immunodeficiency virus (HIV) screening:

- G0432- Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening,

- G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and,

- G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

***In addition to the above codes, e*ffective for claims with dates of service on or after April 13, 2015, the following HCPCS/CPT code may *also* be billed for HIV screening:**

- G0475 - HIV antigen/antibody, combination assay, screening
- *80081 - Obstetric panel*

130.2 - Billing Requirements
(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Medicare Administrative Contractors (MACs) shall recognize the above HCPCS codes for HIV screening in accordance with Publication 100-03, Medicare National Coverage Determinations Manual, section 210.7.

Effective for claims with dates of service on and after December 8, 2009, MACs shall pay for voluntary HIV screening as follows:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,

- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Claims that are submitted for HIV screening shall be submitted in the following manner:

For beneficiaries reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 (Special screening for other specified viral disease) as primary, and V69.8 (Other problems related to lifestyle), as secondary.

For beneficiaries not reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 as primary, and one of the following ICD-9 diagnosis codes: V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy), as secondary.

Effective for claims with dates of service on or after April 13, 2015, MACs shall also pay for voluntary, HIV screening as follows (replacing ICD-9 with ICD-10 beginning October 1, 2015):

For pregnant Medicare beneficiaries, claims shall contain HCPCS code *G0432, G0433, G0435,* G0475 or CPT-80081 with primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, along with one of the following ICD-9/ICD-10 diagnosis codes as secondary listed below, and allow no more than 3 HIV screening tests during each term of pregnancy beginning with the date of the 1st test:

ICD-9: V22.0 Supervision of normal first pregnancy
ICD-10: 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
ICD-9: V22.1 Supervision of other normal pregnancy
ICD-10: 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
ICD-9: V23.9 Supervision of unspecified high-risk pregnancy
ICD-10: 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

For non-pregnant Medicare beneficiaries, claims shall contain HCPCS code *G0432, G0433, G0435,* or G0475 for beneficiaries between 15 and 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary regardless of risk factors. If primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present and the beneficiary is between 15 and 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

For non-pregnant Medicare beneficiaries, *c*laims shall contain HCPCS code *G0432, G0433, G0435*, or G0475 for beneficiaries less than 15 and greater than 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/ Z11.4 as primary, and one of the following secondary ICD-9/ICD-10 diagnosis codes:

V69.8 (Other problems related to lifestyle)/Z72.89 (Other problems related to lifestyle)
Z72.51 (High risk heterosexual behavior)
Z72.52 (High risk homosexual behavior)
Z72.53 (High risk bisexual behavior)

If ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present as primary and one of the ICD-9/ICD-10 secondary codes listed above is not present and the beneficiary is less than 15 or greater than 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

130.3 - Payment Method

(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Payment for HIV screening, HCPCS codes G0432, G0433, G0435, is under the Medicare Clinical Laboratory Fee Schedule (CLFS) for Types of Bill (TOB) 12X, 13X, 14X, 22X, and 23X beginning January 1, 2011. For TOB 85X payment is based on reasonable cost. Deductible and coinsurance do not apply. Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted procedure code 87999. Between April 5, 2010, and January 1, 2011, HCPCS codes G0432, G0433, and G0435 will be contractor priced.

Payment for HIV screening, HCPCS code G0475, for institutional claims will be under the Medicare CLFS for TOB 12X, 13X, 14X, 22X, and 23X for claims on or after January 1, 2017. For TOB 85X payment is based on reasonable cost.

Effective for claims with date of service from April 13, 2015 through December 31, 2016, HCPCS code G0475 will be contractor priced. Beginning with date of service January 1, 2017 and after, HCPCS code G0475 will be priced and paid according to the CLFS.

HCPCS code G0475 will be included in the January 2017 CLFS, January 1, 2016 IOCE, the January 2016 OPPS and January 1, 2016 MPFSD. HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPPS.

A/B MACs (B) shall only accept claims submitted with a G0475, *G0432, G0433, or G0435* with a Place of Service (POS) Code equal to 81 Independent Lab, and 11, Office.

Deductible and coinsurance do not apply.

130.4 - Types of Bill (TOBs) and Revenue Codes

(Rev. 3461; Issued: 02-05-16; Effective: 04-13-15; Implementation: 03-07-16 - non-shared A/B MAC edits; 07-05-16 - CWF analysis and design; 10-03-16 - CWF Coding, Testing and Implementation, MCS, and FISS Implementation; 01-03-17 - Requirement 9403.04.9)

The applicable bill types for HIV screening, HCPCS codes G0432, G0433, G0435, and G0475 are: 12X, 13X, 14X, 22X, 23X, and 85X. (Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.) Use revenue code 030X (laboratory, clinical diagnostic).

A/B MACs (A) shall apply contractor pricing for HCPCS code G0475, HIV screening, for claims with dates of service on and after April 13, 2015 through December 31, 2016.

130.5 - Diagnosis Code Reporting

(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17) A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. *For claims where increased risk factors are reported*: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary and ICD-9/ICD-10 diagnosis code V69.8/Z72.89, Z72.51, Z72.52, or Z72.53, as secondary.

b. *For claims where increased risk factors are NOT reported*: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary only.

c. *For claims for pregnant Medicare beneficiaries*, the following secondary diagnosis codes shall be submitted in addition to primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 to allow for more frequent screening than once per 12-month period:

ICD-9: V22.0 Supervision of normal first pregnancy
ICD-10: 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

ICD-9: V22.1 Supervision of other normal pregnancy
ICD-10: 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

ICD-9: V23.9 Supervision of unspecified high-risk pregnancy
ICD-10: 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

130.6 - Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARCs)

(Rev.3835, Issued: 08-16-17, Effective: 04-13-15, Implementation: 10-02-17)

Effective for dates of service on or after December 8, 2009, when denying claims for HIV screening, HCPCS codes G0432, G0433, or G0435, submitted without ICD-9/ICD-10 diagnosis codes V73.89/Z11.4, or V73.89/Z11.4 and V69.8/Z72.89, use the following messages:

Medicare Summary Notice (MSN) 16.10 - Medicare does not pay for this item or service.

"Medicare no paga por este articulo o servicio"

Claim Adjustment Reason Code (CARC) 167- This (these) diagnosis(es) is (are) not covered.

Group Code CO - (Contractual Obligation)

- *Effective for dates of service on or after December 8, 2009, w*hen denying claims for HIV screening, HCPCS codes G0432, G0433, or G0435, over the benefit maximum, use the following denial messages:

  MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

  "La informacíón proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio."

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  Group Code CO - (Contractual obligation).

- *Effective for dates of service on or after April 13, 2015*, when denying claims for HIV screening, HCPCS code G0432, G0433, G0435, G0475 or CPT-80081 for more than three in a pregnancy term, use the following denial messages:

  CARC 119 – Benefit maximum for this time period or occurrence has been reached.

  Remittance Advice Remark Code (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 NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 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.

MSN: 15.22: "The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

Spanish Version – "La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio."

Group Code - CO

- *Effective for dates of service on or after April 13, 2015*, when denying claims for HIV screening, HCPCS code G0475, if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following secondary ICD-9/ICD-10 diagnosis codes: V69.2/Z72.51, V69.8/Z72.89, V69.2/Z72.52, or V69.2/Z72.53 are not present and the beneficiary is less than 15 and greater than 65 years of age, use the following messages:

CARC 6: "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

RARC N129: "Not eligible due to the patient's age."

(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 NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 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.

Group Code - CO

- *Effective for dates of service on or after April 13, 2015*, when denying claims for HIV screening, HCPCS code G0475, *G0432, G0433, or G0435 is* not submitted with the appropriate, primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, , 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. 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 NCD210.7 were used when we made this decision."

  Spanish Version – "Las siguientes políticas NCD210.7 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.

  Group Code - CO

  Effective for dates of service on or after April 13, 2015, when denying claims for HIV screening, HCPCS code G0475, billed more than once per annum [at least 11 full months must elapse from the date of the last screening], 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."

  (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 policy NCD210.7 was used when we made this decision"

  Spanish Version – "Las siguientes políticas NCD210.7 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.

Group Code - CO

- *Effective for dates of service on or after April 13, 2015*, when denying claims for HIV screening, HCPCS G0475 or CPT-80081 if ICD-9/ICD-10 primary diagnosis code V73.89/Z11.4 and one of the following ICD-9/ICD-10 secondary diagnosis codes are not present for pregnant beneficiaries as listed in section 130.5 (c), use the following denial messages:

CARC 11: The diagnosis is inconsistent with the procedure. 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

(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 NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 fueron utilizadas cuando se tomó 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.

- *Effective for dates of service on or after April 13, 2015, when denying claims for CPT 80081 when submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis codes listed below is not present:*

For ICD-9: V22.0, V22.1, V23.9
For ICD-10: 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, O09.93
Use the following denial 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. 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 NCD210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD210.7 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.*

Group Code – CO

- *Effective for dates of service on or after April 13, 2015, when denying claims for HCPCS 80081when the line –item is submitted with one of the following required HIV primary diagnosis codes:*

For ICD-9: V73.89

For ICD-10: Z11.4

And none of the following secondary diagnosis codes denoting pregnancy are present.

For ICD-9: V22.0, V22.1, V23.9

For ICD-10: 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, O09.93

Use the following denial messages,

CARC 11:
This diagnosis is inconsistent with the procedure. 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 210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.7 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.*

- *Effective for dates of service on or after April 13, 2015, when denying line level claims for G0475, G0432, G0433, G0435 or the CPT code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the Sex Code on the claim indicates 'Male', use the following denial messages:*

CARC 7: The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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 210.7 were used when we made this decision."

Spanish Version – "Las siguientes políticas NCD 210.7 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.*

- *Effective for dates of service on or after April 13, 2015, when denying line-items with POS other than 11 (Office) or 81 (Independent Lab) for the HIV screenings HCPCS G0475, G0432, G0433 and 'G0435, use the following denial 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."

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 210.7 were used when we made this decision.”

Spanish Version – “Las siguientes políticas NCD 210.7 fueron utilizadas cuando se tomó esta decisión.”