CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13423	**Date: September 18, 2025**
	Change Request 14119

SUBJECT: Update to Pub 100-04, Chapter 18 - Preventive and Screening Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Publication 100-04, Medicare Claims Processing Manual, Chapter 18, Section 210 to incorporate Place of Service (POS) code 19 (Off Campus-Outpatient Hospital) as an approved setting for Hepatitis C Virus (HCV) screening services. Additionally, this CR adds the new Healthcare Common Procedure Coding System (HCPCS) code G0567 for HCV screening procedures.

EFFECTIVE DATE: June 27, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 20, 2025

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	18/1.2
R	18/210
R	18/210/210.1
R	18/210/210.2
R	18/210/210.3
R	18/210/210.4

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: 13423	Date: September 18, 2025	Change Request: 14119

SUBJECT: Update to Pub 100-04, Chapter 18 - Preventive and Screening Services

EFFECTIVE DATE: June 27, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 20, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Publication 100-04, Medicare Claims Processing Manual, Chapter 18, Section 210 to incorporate Place of Service (POS) code 19 (Off Campus-Outpatient Hospital) as an approved setting for Hepatitis C Virus (HCV) screening services. Additionally, this CR adds the new Healthcare Common Procedure Coding System (HCPCS) code G0567 for HCV screening procedures.

II. GENERAL INFORMATION

A. Background: The purpose of this CR is to add POS 19 to the list of POS allowed for HCV screening and to add the new code G0567, Infectious agent detection by nucleic acid (dna or rna); hepatitis c, screening, amplified probe technique, to the section to indicate that we would allow coverage for G0567 or G0472. G0567 is effective as of June 27, 2024. This is to comply with the National Coverage Determination (NCD) 210.13 on Screening for Hepatitis C Virus in adults.

B. Policy: This CR implements revisions to the Internet Only Manual (IOM) regarding updated language and coding for National Coverage Determination 210.13 – Screening for Hepatitis C Virus in Adults. No policy change is expected with this instruction.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14119.1	Contractors shall be aware of the POS updates to the IOM Pub. Chapter 18, Section 210.		X							
14119.2	Contractors shall be aware of the new HCPCs code G0567, Screening Hep C detect, which has been added to the IOM Pub. 100-04 Chapter 18, Section 210.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

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

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents

(Rev. 13423; Issued: 09-18-25)

1.2 – Table of Preventive and Screening Services

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	**B**	WAIVED

	83036	Hemoglobin A1C Level	**B**	WAIVED

Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**

	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED

	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	**A**	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED

	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED

	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		WAIVED

Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	**B**	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment.		WAIVED

	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
NOTE: Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.				
Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.				
For dates of service in calendar year (CY) 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible, and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	**A**	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED

	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
	81528	Oncology (colorectal) screening, quantitative real -time target and signal amplification of 10 DNA markers		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED
	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived

Prostate Cancer Screening	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**I**	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived

Influenza Virus Vaccine		For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html		
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	**B**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED

	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED

	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED

	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED

	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use		WAIVED
	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Pneumococcal Vaccine	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	**B**	WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED

	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED

	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED
	G0567	*Screening Hep C detect*	***B***	***WAIVED***

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED

	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED

Intensive Behavioral	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
Therapy for Obesity	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	See link	https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies		WAIVED

210 - Screening for Hepatitis C Virus (HCV)

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

Effective for services furnished on or after June 2, 2014, Medicare covers screening for hepatitis C Virus (HCV) with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

A. Frequency

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

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

3. Repeat HCV screening for a sub-set of high risk persons regardless of birth year is covered annually only for persons who have had continued illicit injection drug use since the prior negative HCV screening test.

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

B. Determination of High Risk for Hepatitis C Disease

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

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

NOTE: Beneficiary coinsurance and deductibles do not apply to claim lines containing HCPCS G0472, hepatitis C antibody screening for individual at high risk and other covered indication(s) *or G0567, Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, screening, amplified probe technique*.

210.1 – Institutional Billing Requirements

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

Effective for claims with dates of service on and after June 2, 2014, providers may use the following types of bill (TOBs) when submitting claims for screening for HCV screening, HCPCS G0472 *or, effective for claims with dates of service on or after June 27, 2024, G0567*: 13X, 14X, and 85X. Service line-items on other TOBs shall be denied.

The service shall be paid on the basis shown below:

- Outpatient hospitals – TOB 13X - based on Outpatient Prospective Payment System (OPPS)
- Non-patient laboratory specimen – TOB 14X – based on laboratory fee schedule
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost

NOTE: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Note: HCPCS G0567 "Screening Hep C detect" has been added to the CLFS on April 1, 2025 with a retroactive effective date back to June 27, 2024.

210.2 - Professional Billing Requirements

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, only when services are ordered by the following provider specialties found on the provider's enrollment record:

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

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

For claims with dates of service on or after June 2, 2014, Medicare will allow coverage for HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, 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

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

Coinsurance and deductibles do not apply to claim lines containing HCPCS G0472 or G0567 (Effective June 27, 2024).

Note: HCPCS G0567 "Screening Hep C detect" has been added to the CLFS on April 1, 2025 with retroactive date back to June 27, 2024.

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

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

Contractors shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*:

Denying services submitted on a TOB other than 13X, 14X, or 85X:

CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N95 – This provider type/provider specialty may not bill this service.

MSN 21.25: This service was denied because Medicare only covers this service in certain settings.

Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

Denying services where previous HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, is paid in history for claims with dates of service on and after June 2, 2014, and the patient is not deemed high risk by the presence of ICD-10 diagnosis code Z72.89, other problems related to lifestyle, and ICD-10 diagnosis code F19.20, other psychoactive substance dependence, uncomplicated:

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

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/medicare-coverage-database/search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 – The following policy NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

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

NOTE: This edit shall be overridable.

Denying services for HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, for beneficiaries at high risk who have had continued illicit drug use since the prior negative screening test, when claims are not submitted with ICD-10 diagnosis code Z72.89, and ICD-10 diagnosis code F19.20, and/or 11 full months have not passed since the last negative HCV screening test:

CARC 167 – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20: The following *policy NCD210.13* were used when we made this decision.

Spanish Version – Las siguientes politicas *NCD210.13* fueron utilizadas cuando se tomo esta decision.

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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

NOTE: This edit shall be overridable.

Denying services for HCV screening, G0472 *or G0567 (Effective June 27, 2024)*, for beneficiaries who do not meet the definition of high risk, but who were born from 1945 through 1965, when claims are submitted more than once in a lifetime:

CARC 119: “Benefit maximum for this time period or occurrence has been reached.”

RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/medicare-coverage-database/search.aspx.* If you do not have web access, you may contact the contractor to request a copy of the NCD.”

MSN 15.20 – The following policy NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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

NOTE: This edit shall be overridable.

Denying claim lines for HCV screening, G0472 *or G0567 (Effective June 27, 2024)*, without the appropriate POS code:

CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428 - Not covered when performed in certain settings.

MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

Spanish Version: "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

Denying claim lines for HCV screening, G0472 *or G0567 (Effective June 27, 2024)*, that are not submitted from the appropriate provider specialties:

CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N574 – Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.

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

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

Denying claim lines for HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, if beneficiary born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 or F19.20 or Z11.59:

CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/medicare-coverage-database/search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

MSN 15.20 – The following policy NCD210.13 were used when we made this decision.

Spanish Version – Las siguientes politicas NCD210.13 fueron utilizadas cuando se tomo esta decision.

Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

210.4 - Common Working File (CWF) Edits

(Rev. 13423; Issued: 09-18-25; Effective: 06-27-24; Implementation: 10-20-25)

The common working file (CWF) shall apply the following frequency limitations to HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*:

One initial HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, for beneficiaries at high risk, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented),

Annual HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, when claims are submitted with ICD-9 diagnosis code V69.8/ICD-10 diagnosis code Z72.89 (once ICD-10 is implemented), and ICD-9 diagnosis code 304.91/ICD-10 diagnosis code F19.20 (once ICD-10 is implemented),

Once in a lifetime HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)*, for beneficiaries who are not high risk who were born from 1945 through 1965.

NOTE: These edits shall be overridable.

NOTE: HCV screening, HCPCS G0472 *or G0567 (Effective June 27, 2024)* is not a covered service for beneficiaries born prior to 1945 and after 1965 who are not at high risk (absence of ICD-10 diagnosis code Z72.89 and/or F19.20 and/or Z11.59 ICD-10 diagnosis code.