

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – The publication titled “Evaluation and Management Services Guide” (revised December 2010), is now available in print format from the Medicare Learning Network®. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations. The “1995 Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services” are included in this publication. To place your order, visit <http://www.cms.gov/MLNGenInfo> on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

MLN Matters® Number: MM6786 **Revised**

Related Change Request (CR) #: 6786

Related CR Release Date: April 22, 2011

Effective Date: December 8, 2009

Related CR Transmittal #: R2199CP and R131NCD Implementation Date: July 6, 2010

Screening for the Human Immunodeficiency Virus (HIV) Infection

Note: This article was revised on April 27, 2011, to reflect the revised CR 6786, which was issued on April 22, 2011. In this article, the CR transmittal number, release date, and the Web address for accessing the CR were changed. All other information is the same.

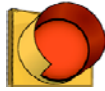
Provider Types Affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors (Fiscal Intermediaries (FI), carriers, and Parts A/B Medicare Administrative Contractors (A/B MAC)) for services to Medicare beneficiaries.

Provider Action Needed

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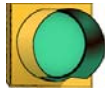
STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.



CAUTION – What You Need to Know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the National Coverage Determination (NCD) Manual, sections 190.14 and 210.7, and the Medicare Claims Processing Manual (CPM), chapter 18, section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Effective January 1, 2009, the CMS is authorized to add coverage of “additional preventive services” through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786.
NOTE: 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

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- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

NOTE: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The USPSTF guideline upon which this policy is based contains 8 increased-risk criteria. The first 7 require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

NOTE: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following 3 new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 Outpatient Code Editor and the January 2011 Clinical Laboratory Fee Schedule (CLFS) updates:

- 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.

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached.) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (Types of Bills 12X, 13X,

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or 14X) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Prior to inclusion of the new G Codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009 through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional Information

CR 6786 consists of two transmittals, the first of which is at <http://www.cms.gov/Transmittals/downloads/R2199CP.pdf> and that transmittal updates the "Medicare Claims Processing Manual". The other transmittal updates Medicare's NCD manual and that is at <http://www.cms.gov/Transmittals/downloads/R131NCD.pdf> on the CMS website.

If you have questions, please contact your Medicare FI, carrier, or A/B MAC, at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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