



Screening for the Human Immunodeficiency Virus (HIV) Infection – JA6786

Related CR Release Date: March 23, 2010

Date Job Aid Revised: May 24, 2010

Effective Date: December 8, 2009

Implementation Date: July 6, 2010

Key Words MM6786, CR6786, R1935CP, R118NCD, HIV, Infection, Screening

- Contractors Affected**
- Fiscal Intermediaries (FIs)
 - Medicare Carriers
 - Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Types Affected Physicians, providers, and clinical diagnostic laboratories submitting claims to FIs, carriers, and A/B MACs for services to Medicare beneficiaries



Change Request (CR) 6786 provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

New National Coverage Determination (NCD)

Provider Needs to Know...

- The Centers for Medicare & Medicaid Services (CMS) has issued a new NCD that the evidence is adequate to conclude that screening for HIV infection 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.
 - 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 *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.
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Implementation of New Codes

- 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 antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening,
 - **G0433** - Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening, and
 - **G0435** - Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.

Claims for Annual HIV Screening

- Claims for the annual HIV screening must contain one of the new Healthcare Common Procedure Coding System (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.

Denied HIV Screening Claims

- 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.
- If an Advance Beneficiary Notice (ABN) is provided, Group Code PR (patient responsibility) is used.
- If an ABN is not provided, Group Code CO (contractual obligation) is used.

Medicare Payment of HIV Screening Tests

- Medicare contractors will pay for HIV screening tests with HCPCS codes G0432, G0433, or G0435 on TOB 85X under reasonable cost.
 - 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, or 14X) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.
 - Contractors will pay for HIV screening tests with HCPCS codes G0432, G0433, or
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G0435 on TOBs 12X, 13X, 14X, 22X, and 23X, under the clinical laboratory fee schedule as of January 1, 2011.

- Deductible and coinsurance do not apply.
 - 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.
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Background

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- Effective January 1, 2009, 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.
 - 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 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 CR6786 (**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); and
 - 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 73.89 (Special screening for other specified viral disease) and 69.8 (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 73.89 for the claim to be paid.
- Note:** Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.
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Operational
Impact

- Medicare will not automatically adjust claims for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR6786 is implemented.
 - However, Medicare contractor will adjust such claims that are brought to their attention.
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Reference
Materials

The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM6786.pdf> on the CMS website.

The official instruction (CR6786) regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1935CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R118NCD.pdf> on the CMS website
