

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



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July 5, 2016 - For CWF and January 1, 2017, for full implementation

Screening for the Human Immunodeficiency Virus (HIV) Infection

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for human immunodeficiency virus (HIV) infection screening services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9403 informs MACs that the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening of HIV infection for all individuals between the ages of 15-65 years is reasonable and necessary for early detection of HIV, and it is appropriate for individuals entitled to benefits under Part A or enrolled in Part B.

Background

On January 1, 2009, CMS was authorized to add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if certain statutory requirements are met. One of those requirements is that the service(s) be categorized as a grade A (strongly

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recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. Previously, the USPSTF strongly recommended screening for all adolescents and adults at increased risk for HIV infection, as well as all pregnant women. The USPSTF made no recommendation for or against routine HIV screening in adolescents and adults not at increased risk for HIV infection. Effective December 8, 2009, CMS issued a final decision supporting the USPSTF recommendations.

[Change Request \(CR\) 6786](#), Transmittal 1935, Screening for Human Immunodeficiency Virus (HIV) Infection, dated March 23, 2010, provides earlier implementation instructions related to NCD210.7. You may review the MLN Matters article related to Transmittal 1935 at **<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6786.pdf>** on the CMS website.

In April 2013, the USPSTF updated these recommendations and recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened (Grade A recommendation). The USPSTF also recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown (Grade A recommendation).

CR 9403 instructs that effective for claims with dates of service on and after April 13, 2015, CMS will cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point-of-care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider for these services, for beneficiaries who meet one of the following conditions below:

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the ages of 15 and 65, without regard to perceived risk.
2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:
 - Men who have sex with men;
 - Men and women having unprotected vaginal or anal intercourse;
 - Past or present injection drug users;
 - Men and women who exchange sex for money or drugs, or have sex partners who do;
 - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
 - Persons who have acquired or request testing for other sexually transmitted infectious diseases;
 - Persons with a history of blood transfusions between 1978 and 1985;

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- Persons who request an HIV test despite reporting no individual risk factors;
 - Persons with new sexual partners; or
 - Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of “increased risk” for HIV infection is identified by the health care 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 recommendation should be a reflection of the service provided.
3. A maximum of three voluntary HIV screenings of pregnant Medicare beneficiaries:
- When the diagnosis of pregnancy is known;
 - During the third trimester; and
 - At labor, if ordered by the woman’s clinician.

NOTE: There is no co-insurance or deductible for tests paid under the Clinical Laboratory Fee Schedule (CLFS).

Billing Requirements

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening.

NOTE: HCPCS G0475 will appear in the January 1, 2017, CLFS; in the January 1, 2016, Integrated Outpatient Code Editor (IOCE); in the January 2016 Outpatient Prospective Payment System (OPPS); and in the January 1, 2016, Medicare Physician Fee Schedule (MPFS). HCPCS Code G0475 will be effective retroactive to April 13, 2015, in the IOCE and OPPS.

For services from April 13 - September 30, 2015, inclusive, the diagnosis codes are:

ICD-9 Code	Descriptor
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V23.9	Supervision of unspecified high-risk pregnancy
V69.8	Other problems related to lifestyle
V73.89	Special screening examination for other specified viral diseases
V69.2	High risk sexual behavior

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For dates of service on or after October 1, 2015, the diagnosis codes are:

ICD-10-CM	Long Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, second trimester
Z34.93	Encounter for supervision of normal pregnancy, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester
Z72.89	Other problems related to lifestyle
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior

On professional claims, the place of service must be either 81 (independent laboratory) or 11 (office).

If claims are received for screenings that exceed the maximum number allowed per year, the claim line item will be denied with the following remittance codes:

- Claim Adjustment Reason Code (CARC) 119: “Benefit maximum for this time period or occurrence has been reached.”

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- 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 on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.” and
- Group Code: CO (Contractual Obligation).

Note that the next eligible date for the service will be provided on all Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

Claims with HCPCS Code G0475 for beneficiaries between the ages of 15 and 65 without regard to risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10). If that primary code is not present, the line item will be denied using the following messages:

- CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code: CO (Contractual Obligation).

Claims with HCPCS Code G0475 for beneficiaries less than age 15 or greater than age 65 with increased risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10) and a secondary diagnosis code that denotes the high risk. The ICD-9 secondary codes are V69.2 or V69.8. The ICD-10 secondary diagnosis codes are Z72.51, Z72.89, Z72.52, or Z72.53. If that secondary code is not present, the line item will be denied using 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.”
- Group Code: CO (Contractual Obligation).

Effective for claims with dates of service on or after April 13, 2015, MACs will deny line-items on claims for pregnant beneficiaries denoted by a secondary diagnosis code above denoting pregnancy, if HCPCS Code G0475, HIV screening, or CPT code 80081, obstetric panel, and primary diagnosis code V73.89/ Z11.4, as appropriate, are not present on the claim. Such line item denials will result in the following remittance 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.”

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Institutional claims for G0475 submitted on Types of Bill (TOB) 12X, 13X, 14X, 22X, and 23X will be paid based on the CLFS with dates of service on or after January 1, 2017. MACs will apply their pricing to claims with dates of service of April 13, 2015, through December 31, 2016. Such claims submitted on TOB 85X will be paid based on reasonable cost for dates of service beginning with April 13, 2015.

Additional Information

The official instruction, CR 9403, was issued to your MAC via two transmittals. The first updates the NCD Manual and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R190NCD.pdf> on the CMS website. The second transmittal updates the “Medicare Claims Processing Manual” and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3461CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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