Billing Manual for HIV Testing And Related Services

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HIV Third-Party Billing Project

Acknowledgement

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Disclaimer

This guide is designed for informational purposes only and should not be interpreted as legal advice. The purpose of this manual is to provide guidance on billing for HIV testing and preventative services. It is important to note that HIV billing and coding is a dynamic process and rules and regulations may change. Also, HIV reimbursements may vary based on the third party that is being billed. It is the responsibility of providers to correspond with each individual third -party payer if problems arise with reimbursements.

Executive Summary

In July 2015, the White House released the National HIV/AIDS Strategy (NHAS) for the United States. It focused on four outcomes:[1]

1. Viral suppression and reduction of new HIV infections
2. Widespread testing and increased access to care to improve health outcomes for people living with HIV (PLWH)
3. Reduction of HIV-related health disparities and inequities
4. Development of programs that offer a more coordinated national response to the HIV epidemic

In accordance with the National HIV/ AIDS Strategy, local health departments (LHDs), community-based organizations (CBOs), and other healthcare providers (HCPs) provide preventive services that help to minimize the spread of infectious diseases such as HIV. Traditionally, these providers have either not charged, or charged a nominal fee, for these services. However, recent changes in healthcare policies and reductions in state and federal funding have forced providers to begin seeking alternative methods of reimbursement for these vital services.

[1] (*National HIV/AIDS Strategy for the United States: Updated to 2020*.) https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update

With this in mind, the Illinois Public Health Association (IPHA) was awarded a grant from the Illinois Department of Public Health (IDPH) to assist LHDs, CBOs, and HCPs to build their capacity to bill third-party payers for routine HIV screening and HIV prevention services.

The purpose of this guide is to discuss how LHDs, CBOs, and HCPs can develop the capacity to bill for HIV services, a vital HIV prevention component of NHAS.

Providing HIV services can enable providers to enhance their HIV prevention intervention resources, reach more at-risk populations that are in need of HIV prevention services, and generate new sources of revenue. Without HIV billing capacity, LHDs, CBOs, and HCPs may eventually face the need to discontinue these vital services, thus diminishing patient access to care.

General Coding Principles

Insurance companies pay for services based on "Procedure Coding" or CPT codes. In some instances, a set of services will be reimbursed at a "bundled" rate instead of based on fee-for-service (a bundled payment covers multiple services, and may include services provided by two or more providers for a single episode of care). The American Medical Association developed CPT codes to describe services performed by healthcare providers. Individual insurance companies and state Medicaid are not required to cover all services described by the CPT codes.

All services require an International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code in order to be reimbursed. A medical practice or health department could provide a service that is covered and described by a CPT code, but not have the correct ICD-10 code that justifies reimbursement by the payer. This may result in the claim being rejected and the service not being reimbursed. Therefore, the following are required for reimbursement:

1. The correct CPT code
2. Services must be performed by a licensed provider or under the supervision of the credentialed licensed provider.
3. Supported by an allowable ICD-10 diagnosis code. In the case of HIV care, the ICD-10 code is B-20.

4. The appropriate Modifier code. Modifier codes are used to report special circumstances and to clarify or modify the description of the procedure.

Current Procedural Terminology (CPT) Coding

These are 5-character procedural codes used by insurers to help determine the amount of reimbursement that a practitioner will receive for services provided. They fall into 3 categories:

Category I – These five-digit codes have descriptors which correspond to a procedure or service. Codes range from 00100 – 99499. CPT codes are used for Evaluation and Management (E/M), but can also be assigned to vaccinations.

Category II – These alphanumeric tracking codes are optional and designed for data collection. They are designed to be used for quality improvement.

Category III – These are provisional codes for new and developing technology, procedures, and services. The codes were created for data collection and assessment of new services and procedures.

For the purpose of this guide, we will only reference Category I.

Coding E & M Visits (CPT codes)

- **Levels of service are based on key components:**
  - History of the illness; new or established patient
  - Examination; how many body systems were evaluated
  - Medical decision-making complexity
- **Contributory factors include:**
  - Counseling
  - Coordination of care; this is becoming much more important
  - Nature of the presenting problem
  - Time spent with the patient (This should not be the deciding value)
- CPT Codes for Evaluation & Management Visits (E & M 99201- 99215) can only be billed if patient is seen by a "qualified" provider (e.g., MD, NP, PA, or CNM)

- New Patient Visits 99201 – 99205
- Established Patient Visits 99211 – 99215

Coding Criteria for an Established Patient [2]

CPT Code	99211	99212 Problem Focused	99213 Expanded Problem Focused	99214 Detailed
Chief Complaint	Required	Required	Required	Required
History*	Minor Problem Provider not Required	1-3 HPI	1-3 HPI 1 ROS	4 HPI 10+ ROS 1 pertinent PFSH
Exam*		1-5 bulleted items	6 bulleted items	12 bulleted items
Medical Decision Making*		Straightforward	Low	Moderate
Time (min)	5	10	15	25

*Three of these components must be met to qualify for the level of service.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Diagnosis Coding (ICD-10-Z-Codes)

Z codes are ICD-10-CM codes that represent reasons for encounters. If a procedure is performed, a Z code must follow the CPT code.

Categories Z00-Z99 : used when circumstances other than a disease, injury or external cause are used as “diagnoses” or “problems”. This can arise in two main ways:

1. When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive an immunization, or to discuss a problem which is in itself not a disease or injury.
2. When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Coding and Reporting Guidelines for Diagnosis Coding:

1. Use the ICD-10-CM codes that describe the patient's diagnosis, symptom, complaint, condition, or problem.

2. Use the ICD-10-CM code that is chiefly responsible for the item or service provided.

3. Assign codes to the highest level of specificity.

4. Do not code suspected diagnoses in the outpatient setting. Code only the diagnosis symptom, complaint, condition, or problem reported. Medical records, not claim forms, should reflect that the services were provided for "rule out" purposes.

5. Code a chronic condition as often as applicable to the patient's treatment.

6. Code all documented conditions, which coexist at the time of the visit that require or affect patient care or treatment. Do not code conditions which no longer exist.

ICD-10-CM Coding for HIV

Z-Codes Assigned with ICD-10 Code B-20

1) Z11.4 - Encounter for HIV screening
2) Z11.3 - Encounter for screening for infection from predominately sexual mode of transmission
3) Z 20.2 - Contact with and suspected exposure to infection with predominately sexual mode of transmission (most commonly used for PrEP)
4) Z 21 - Asymptomatic HIV
5) Z 20.6 - Contact with and suspected exposure to HIV infected person
6) Z51.81 - Encounter for therapeutic drug monitoring (PrEP)
7) Z71.7 - HIV counseling
8) Z 72.51 - High risk heterosexual behavior
9) Z 72.52 - High risk homosexual behavior
10) Z 72.53 - High risk bisexual behavior
11) Z 72.89 - Other problems related to lifestyle (drug seeking, unhealthy drinking behavior)
12) Z 79.899 - Other long term (current) drug therapy (PREP)
13) Z 86.59 - Personal history of other mental and behavioral disorder
14) Z 87.898 - History of drug use, non-dependent in remission
15) Z01. 812 - Encounter for procedural lab exam
16) R75 - Inconclusive HIV lab test
17) F 11.20 - Opioid dependence, uncomplicated
18) F 11.21 - Opioid dependence in remission
19) F 11.10 - Opioid abuse, uncomplicated
20) F11.9 - Opioid use, uncomplicated

Preventive Medicine Billing

An alternative billing method for HIV testing is to bill for the counseling with "Preventive Medicine" codes. CPT has a series of preventive medicine codes for risk factor reduction. The preventive medicine codes are intended to be **used in the absence of an**

established diagnosis and used to guide risk reduction. Note that Medicare and some Medicaid plans may not reimburse for this method, however private insurance will.

These codes that are based on time that is spent face-to-face with the patient

- **99401** approximately 15 minutes
- **99402** approximately 35 minutes
- **99403** approximately 45 minutes
- **99404** approximately 60 minutes

If the patient is being seen by an RN or other non-licensed staff, then the following can be billed:

- **98960** Self-management education and training face-to-face, 1 patient

Shared Medical Visit Billing Method

A shared medical appointment, also known as a group visit, occurs when multiple patients are seen as a group for follow-up care or management of chronic conditions. These visits are voluntary for patients, and designed to provide a secure and interactive setting in which patients have improved access to their physicians. The patient also benefits by receiving counseling from additional members of a health care team (for example a behaviorist, nutritionist, or health educator), and can share experiences and advice with their peers. *Note that the status indicator (Medicare) for group visits is bundled so this service may not be paid.*

Codes: Use CPT code 99708

This code may only be reported by a provider. Although they cannot perform the service, staff members could participate in the shared medical appointment, but the provider needs to document the services in the patient's record.

How to use these codes for shared medical appointments:

Some providers bill for a shared medical visit. In this case, the provider may see the patient in the presence of other group members. In this case, the provider must document the encounter in each patient's chart. The level of service is based on key components such as history, exam and medical decision making; not on the length of the group appointment.

Overview of a Group Visit[3]

• Patients meet as a group, with a team consisting of a physician or nurse practitioner, and in some cases, a nurse and/or behavioral specialist

• The group usually meets for 1.5 to 2.5 hours, at a periodic interval that is appropriate for the medical need and condition

• The structure emphasizes an interdisciplinary approach to the medical care visit and can be used for a wide range of medical conditions

• Each group session includes an individualized medical review by a licensed practitioner, patient education, and a facilitated group discussion

• Billing is based on standard medical and behavioral billing practice

Coding Modifiers

Since medical procedures and services are often complex and additional information is needed, CPT Modifiers may be assigned. They describe whether multiple procedures were performed, why that procedure was necessary, where the procedure was performed anatomically, and other information that may be critical to a claim's status with the insurance payer.

CPT Modifiers are always two characters, and may be numeric or alphanumeric (most are numeric).

CPT modifiers are added to the end of a CPT code with a hyphen. If more than one modifier can be assigned, code the "functional" modifier first, and the "informational" modifier second. The modifier that most directly affects reimbursement should be used first.

There are three modifiers that could be used when screening for HIV:

1. **Modifier 33**: This modifier is assigned when the service is rated either "A" or "B" by the US Preventative Service Task Force (USPSTF). Patients cannot be charged for these services. An "A" rated test indicates a high certainty that the

[3] https://www.massgeneral.org/stoecklecenter/assets/pdf/group_visit_guide.pdf

test is beneficial to the patient. "B" indicates that here is high certainty that the patient benefits moderately from the test. ***HIV testing is categorized as a grade "A," so there is no charge to the patient.***

2. **Modifier 92: Alternative - Laboratory Platform Testing:** When laboratory testing is being performed using a disposable or transportable, single-use kit, consider adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require a permanent dedicated space and may be hand-carried or transported to the vicinity of the patient for immediate testing at that site.
3. **Modifier QW**: CLIA-waived test. CLIA-waived tests on this list are 86701, G0433, G0434, and 87389

CMS HCPCS Codes[4]

There is also a third major code set, **Healthcare Common Procedure Coding System** (HCPCS), commonly referred to as "hicks-picks." These codes were developed by the Centers for Medicare and Medicaid (CMS). These codes were optional until HIPPA was passed in 1996. Today, coders today use HCPCS codes to represent medical procedures to Medicare, Medicaid, and several other third-party payers. Level I codes are identical to CPT, though technically those codes, when used to bill Medicare or Medicaid, are HCPCS codes. *Remember, Medicare does not pay LHDs for these services.* Coders use HCPCS Level II just as they would CPT. If there is equipment, certain professional services, injected medication, or any number of things listed on the report that aren't found in CPT, the coder should use HCPCS Level II. Therefore, the following screening codes are used to indicate the specific tests performed:

1. **G0432** Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and HIV-2 screening
2. **G0433** Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and HIV-2 screening
3. **G0435** Infectious agent HIV-1 and HIV-2 rapid antibody test

[4] http://www.hcpro.com/HIM-284009-8160/Note-similarities-and-differences-between-HCPCS-CPT-codes.html

General Information on HIV Testing

HIV tests can be performed and billed to any insurance company regardless if it is a Medicaid/MCO plan or a commercial/private plan, however, Medicare will not reimburse LHDs for HIV services because of Roster Bill enrollment.

It is critical that HIV-infected persons be made aware of their HIV status. In 2014, CDC estimated that 15% of all persons living with HIV in the United States had undiagnosed infections. Early HIV care and adherence to antiretroviral therapy (ART) prolong life, decrease the chances of HIV transmission, and reduce the cost of care. Early diagnosis of HIV infection and linkage to care are essential not only for the patients' own health but also to reduce the risk for transmitting HIV to others.

Additionally, it is important to continually monitor individuals who are receiving treatment for HIV for the development of resistance.

Finally, with the development of pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and maternal HIV treatment, HIV and AIDS can now be prevented.

Code only confirmed cases of HIV infection/illness. Confirmation does not require documentation of positive serology or culture for HIV; **the provider's diagnostic statement that the patient is HIV-positive, or has an HIV-related illness is sufficient**[5].

Asymptomatic HIV (Z 21) infection status is to be applied when the patient does not have any documentation of symptoms but is diagnosed as being HIV-positive. This code should not be used if the medical record indicates the term AIDS or the patient is being treated for any condition resulting from HIV.

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75.

Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be

[5] https://www.aapc.com/blog/34554-hiv-icd-10-dx-coding/

assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic HIV infection status.

Care of People Living with HIV and AIDS (PLWHA) should include behavioral and psychosocial services, especially for alcohol and drug addiction and for mental health problems.

Encounters for Testing for HIV

If a patient is being seen to determine his/her HIV status, use code Z11.4, "Encounter for screening for human immunodeficiency virus [HIV]." Additional codes can be used when addressing high-risk behaviors. If a patient with signs or symptoms is being seen for HIV testing, then code the signs and symptoms. An additional counseling code Z71.7, HIV counseling, may be used if counseling is provided during the encounter for the test. When a patient returns to be informed of his/her HIV test results and the test result is negative, use code Z71.7, HIV counseling. If the results are positive, the ICD-10 code (B20) should be assigned.

HIV Testing Guidelines (See Also Appendix 1)

Generalized Testing:

It is generally recommended that all patients aged 13-64 seeking health care for any reason undergo HIV testing. Additionally, all pregnant women should be tested to prevent perinatal HIV transmission. This is done to identify women who should be treated with antiretroviral therapy during pregnancy.

Additionally, patients who are at high risk based on behavioral practices or high-risk demographics should be tested annually. This includes men who have sex with men (MSM), people who inject drugs (PWID), sex workers, transgender populations, and prisoners. This also includes patients who present for treatment for sexually transmitted diseases.

HIV infection/illness is coded as a diagnosis only for confirmed cases. Confirmation does not require documentation of a positive blood test or culture for HIV; the physician's diagnostic statement that the patient is HIV-positive or has an HIV-related illness is sufficient.[6]

High-Risk Testing:

HIV testing can be initiated when there is strong clinical suspicion. Conditions that support diagnostic testing include:

1. A documented, otherwise unexplained, AIDS-defining illness (see appendix)
2. A documented sexually transmitted disease which identifies significant risk of exposure to HIV (ex. Chlamydia, genital warts).
3. A documented acute or chronic Hepatitis B or C infection
4. The patient has a documented AIDS-associated neurologic disorder or otherwise unexplained dementia
5. Persistent conditions which suggest an underlying immune deficiency (for example, cutaneous or mucosal disorders).
6. Unexplained generalized signs and symptoms suggestive of a chronic process (for example, fever, weight loss, malaise, fatigue, chronic diarrhea, failure to thrive, chronic cough, hemoptysis, shortness of breath, or lymphadenopathy).
7. Unexplained laboratory evidence of a chronic disease process with an underlying immune deficiency (for example, anemia, leukopenia, pancytopenia, lymphopenia, or low CD4+ lymphocyte count).
8. Unexplained fever, malaise, lymphadenopathy, and skin rash.
9. Documented exposure to blood or body fluids known to be capable of transmitting HIV (for example, needle sticks and other significant blood exposures) and antiviral therapy is initiated or anticipated to be initiated.

[6] https://www.aapc.com/blog/34554-hiv-icd-10-dx-coding/

10. The patient is undergoing treatment for rape. (HIV testing is part of the treatment protocol).

Pre-Test Counseling (25-30 minutes)

Possible Billing: CPT 99214, Z 71.7

(Because the patient's HIV status is not known, B20 cannot be used)

Prior to testing for HIV, individuals should receive pre-test counseling to discuss the nature of the test and the consequences of both negative, positive, and indeterminate test results. At this visit, informed consent should be obtained. The patient should be asked about their knowledge of condom use, sexually transmitted illnesses (STIs), and HIV/ AIDS. In case of a negative result, the patient should be informed about the window period for antibody-based tests and the need for retesting after about 3 months, depending on risk assessment. It is important to stress that a negative result does not imply immunity from infection, and the need for a change in behavior. A follow-up appointment should be scheduled to discuss test results.

Post-Test Counseling (Test Negative), (Z 71.7)

If the patient's HIV test is negative, the patient should be given the results and the patient should be informed that they may be in a window period. This is a 3 month period in which the patient may have contracted the disease but may have not yet seroconverted. If there is reason for concern that this may be the case, schedule an appointment for a retest in about 3-4 months and ask the patient to abstain from unprotected sex or needle sharing during this interval.

Post-Test Counseling (Test Positive), (B20 can be assigned)

After diagnosis, the patient should be counseled on the importance of beginning treatment to prevent disease progression and to reduce disease transmission. It is important to discuss the effectiveness of treatment, and the importance of medication compliance to reduce the possibility of the development of drug resistance. If your clinic does not provide care, the patient should be promptly referred to a healthcare provider or facility experienced in caring for patients with HIV. This is particularly important in patients that have symptoms or signs that suggest advanced HIV infection.

Behavioral and psychological services are integral parts of care for individuals with HIV. Newly diagnosed patients may experience considerable emotional and psychological distress. These patients should receive counseling on issues such as coping with the stigma associated with the disease and developing skills to maintain both physical and emotional health. Additional considerations include addressing behavioral changes to prevent transmission to others and reducing risks for contracting other sexually transmitted illnesses. They may also require assistance with making reproductive choices, gaining access to health services, coping with changes in personal relationships, and partner notification.

Additionally, it is important to consider that some of these patients will require referrals for behavioral interventions such as substance abuse treatment and mental health disorders. Others will require assistance with securing and maintaining employment and housing.

Screening and Counseling to Reduce Alcohol Misuse

The US Preventative Services Task Force (USPSTF) recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. These services should be performed on patients with or without HIV. Screening must be performed by a licensed provider.

Codes:

G0442 - annual alcohol misuse screening, 15 minutes

G0443 - 15 minute behavioral counselling for alcohol misuse

The behavioral counseling should include the following:

1) ASSESS: ask about behavioral risk factors and factors affecting change
2) ADVISE: offer clear, specific behavioral change advice, including information about personal health harms
3) AGREE: select appropriate treatment goals, based on the patient's willingness to change
4) ASSIST: aid the patient in achieving goals by acquiring new skills, supplemented with pharmaceutical intervention if needed
5) ARRANGE: schedule follow up and refer to more intensive treatment if needed

STD Testing During HIV Care

A sexually active patient that is receiving care for HIV should also be tested at least annually for STIs, specifically syphilis, gonorrhea, and Chlamydia. Women with HIV infection should also be screened for trichomonas and undergo Pap testing.

Hepatitis

- **86708** - Hepatitis A antibody (HAAb); total
- **86709** - Hepatitis A antibody (HAAb); IgM antibody
- **86704** - Hepatitis B core antibody (HBcAb); total
- **86705** - Hepatitis B core antibody (HBcAb); IgM antibody
- **86706** - Hepatitis B surface antibody (HBsAb)
- **86707** - Hepatitis Be antibody (HBeAb)
- **86803** - Hepatitis C antibody;
- **86804** - Hepatitis C antibody; confirmatory test (eg, immunoblot)
- **87340** - Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg)
- **87341** - Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis B surface antigen (HBsAg) neutralization
- **87350**- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; hepatitis Be antigen (HBeAg)
- **87902**- Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus
- **87912**- Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis B

Chlamydia

One annual screening is allowable for chlamydia in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy for those who are at increased risk and who continue to be at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for chlamydia in men.

- **86631 -** Antibody Chlamydia
- **86632 -** Antibody Chlamydia, IgM
- **87110 -** Culture, chlamydia, any source
- **87270 -** Infectious agent antigen detection by immunofluorescent technique chlamydia trachomatis
- **87320 -** Infectious agent antigen detection by immunoassay technique (e.g. enzyme immunoassay [EIA], enzyme–linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method, chlamydia trachomatis
- **87490 -** Infectious disease agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, direct probe technique
- **87491 -** Infectious diseases agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, amplified probe technique
- **87810 -** Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis

Syphilis

One annual screening is allowed for syphilis in men or women at increased risk. For pregnant women, one screening per pregnancy; two additional screenings in the third trimester and at delivery if the patient is at increased risk for STIs.

- **86592 -** Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
- **86593 -** Syphilis test, non-troponemal antibody; quantitative
- **86780 -**Treponema pallidum

Gonorrhea

One annual screening is allowed for gonorrhea in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy for those who are at increased risk and who continue to be at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for gonorrhea in men, and this will affect payer policies.

- **87590 -** Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, direct probe technique

- **87591 -** Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, amplified probe technique
- **87592 -** Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, quantification

Special Pregnancy Considerations for HIV Screening

During the first prenatal visit, all pregnant women should be tested for HIV. If the woman tests positive, she will need to be treated with antiviral medication. Additionally, it is important to consider the possibility that her other children may be infected.

Protocol for Step-Wise Testing

Step 1: HIV-1/2 Ag/Ab Combination Immunoassay

CPT Code 87389

HIV diagnostic testing of adults and children aged 2 years and older should ideally begin with an FDA-approved HIV Ag/Ab combination test, also known as a 4th-generation immunoassay. Clinicians should request HIV diagnostic testing from a laboratory that offers a 4th-generation HIV-1/2 Ag/Ab combination immunoassay as an initial screening test.

If this initial immunoassay is reactive, the laboratory should progress directly to the supplemental testing sequence of the recommended HIV diagnostic testing algorithm and follow the recommended testing steps through completion to conclusively confirm or exclude laboratory evidence of HIV infection.

The Ag/Ab combination immunoassays will detect HIV-1 and HIV-2 Abs and HIV-1 p24 Ag, which is present during the acute stage before Ab seroconversion has occurred. As of March 2016, five FDA-approved 4th-generation HIV Ag/Ab combo immunoassays are available. Four of the five use technology that has been validated in combination with the recommended supplemental tests and are approved for use in step 1 of the recommended laboratory algorithm. The four HIV Ag/Ab combo immunoassays that are acceptable for step 1 employ either enzyme

immunoassay or chemiluminescent immunoassay technology and require the use of specific instrumentation to perform the test and/or read the results.

Step 2: HIV-1/2 Ab-Differentiation Immunoassay

CPT Code: 86701, 86702

If the initial screening result is reactive, the laboratory should test the specimen using an HIV-1/2 Ab-differentiation immunoassay that has been FDA-approved for use in the recommended algorithm. If the HIV-1/2 Ab-differentiation test is positive for HIV-1 Abs or HIV-2 Abs, clinicians should proceed with medical evaluation for confirmed HIV-1 or HIV-2 infection. If the specimen is positive for HIV Abs but cannot be differentiated as HIV-1 or HIV-2, clinicians should proceed with medical evaluation for HIV infection.

Step 3: HIV-1 Nucleic Acid Test (NATs) for Diagnosis of Acute and Early HIV-1 Infection

CPT Code 87535

If the HIV-1/2 Ab-differentiation immunoassay is nonreactive or indeterminate, an HIV-1 RNA test should be performed immediately to confirm or exclude evidence of HIV -1 infection. This test is highly sensitive and specific and detects viral nucleic acid in the potential window period.

Miscellaneous Testing Codes

86703 - HIV-1 and HIV-2, single result (rapid)

87389 - HIV-1 antigens, with HIV-1 and HIV-2 antibodies, single result (ELISA)

87389 - CLIA waived test and must have **modifier QW** in order for it to be paid

86689 - HTLV or HIV antibody, confirmatory test (Western Blot) (no longer recommended)

36415 - Venipuncture for a non-rapid test

Monitoring HIV Infections

Quantitative HIV-1 RNA Tests: CPT: 87536

Quantitative HIV-1 RNA tests are widely available and have been approved by the FDA only for monitoring prognosis of HIV-1 infection and response to antiretroviral treatment.

Lab Tests for Patients with HIV

Viral Load (HIV RNA, Quantitative, PCR)	CPT 87536
T Helper Cell Count (CD4)	CPT 86359, 86361
HIV Resistance Testing	CPT 87906
Cytomegalovirus Antibodies	CPT 86644, 86645
Toxoplasma Antibodies	CPT 86777, 86778

Tb Testing

If this is the only service performed on that day, then bill CPT **85680**

- Do not report an injection code **96372** for placing the skin test.
- Do not report a nurse visit for the PPD injection.
- And don't report **90471** for vaccine administration.
- **Z11.1** Encounter for screening for respiratory tuberculosis
  Z20.1 Contact with and (suspected) exposure to tuberculosis

AIDS-Defining Illnesses

- Candidiasis of the esophagus, bronchi, trachea, or lungs, but NOT the mouth (thrush)
- Cervical cancer, invasive
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (greater than one month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)

- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV related
- Herpes simplex: chronic ulcer(s) (more than 1 month in duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (more than 1 month in duration)
- Kaposi sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary, of brain
- Mycobacterium avium complex or M kansasii, disseminated or extrapulmonary
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
- Pneumocystis jiroveci pneumonia
- Pneumonia, recurrent
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

Chronic Care Management (CCM) 99490[7] (HIV-Related Care)

There are many restrictions placed on this code and billing is very limited. This can be performed by supervised staff. ***Cannot be billed where Ryan White Funds cover care management.***

Requirements:

1. At least 20 minutes of clinical staff time per calendar month
2. Two or more chronic conditions expected to last at least 12 months or until death
3. Conditions pose significant risk of death, decompensation or functional decline
4. A provider must develop a comprehensive care plan
5. Must obtain informed consent

[7]https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

6. Includes case management for medical, functional, and psychosocial needs; coordination with in-home or community services

Care Coordination by Community Health Workers (CHWs)

In 2013, Federal CMS began allowing for Medicaid coverage for non-licensed professionals with recommendation from a health care provider[8]. Therefore, services provided by CHWs, as well as Peer Counselors, may be reimbursed. Unfortunately, Illinois is still a work in progress and currently does not reimburse for CHW services. Work to allow this continues in Illinois.

The following codes are provided for completeness:

- **98960** - Self management education and training, face-to-face, 1 patient
- **98961** - Self management education and training face-to-face, 2-4 patients
- **98962** - Self management education and training face-to-face, 5-8 patients
- **T-1017** - Targeted case management, each 15 minutes

Federal Medicaid Reimbursement for Peer Advocates and CHWs[9]

Medicaid-Reimbursable Preventive Services Delivered by Peer Advocates	Medicaid-Reimbursable Preventive Services Delivered by Community Health Workers
Testing for HIV	Providing basic screening services
Referring and linking patients to medical care; conducting outreach to re-engage patients not regularly receiving care	Ensuring that patients obtain necessary health care services
Providing orientation and counseling to new patients	Providing informal counseling and social support

[8] https://hivcareconnect.com/reimbursable-services/

[9] https://hivcareconnect.com/reimbursable-services/

Medicaid-Reimbursable Preventive Services Delivered by Peer Advocates	Medicaid-Reimbursable Preventive Services Delivered by Community Health Workers
Helping patients to navigate the health insurance and health care systems; addressing barriers to care access and retention	Providing cultural mediation between communities and health and human services systems
Providing health education focusing on treatment adherence at appropriate literacy level	Assisting with providing culturally appropriate health education

Billing for Pre-exposure Prophylaxis (PrEP)

PrEP is an epidemic-changing HIV prevention tool used to lower the chances of individuals with HIV risk from acquiring the virus. According to the Centers for Disease Control and Prevention (CDC), PrEP has been shown to reduce the risk of HIV infection in high-risk populations by up to 92% if taken consistently. However, it is much less effective if taken inconsistently[10]. A combination of two HIV medicines (Tenofovir and Emtricitabine), sold under the brand name Truvada, is approved for daily use as PrEP to help prevent an HIV-negative person from contracting HIV from a sexual or injection-drug-using partner who is HIV-positive.

Most public and private insurers cover PrEP, but co-pays, co-insurance, and prior authorization policies differ. Both Medicaid, as well as Medicare, cover PrEP. Medicaid often requires prior authorization to obtain a pre-approval for PrEP. Medicare Part D provides prescription drug coverage, including PrEP.

Labs for PrEP Initiation

The lab tests described below are ordered by a billable healthcare professional prior to PrEP initiation. They may also be ordered in other situations for HIV and STI screening.

[10] *https://www.cdc.gov/hiv/risk/prep/index.html*

Prior to starting PrEP, the provider orders screening laboratory tests which include HIV serology, and screening for sexually transmitted infections. The medical provider may also order a metabolic panel and/or pregnancy test. After starting PrEP medication, the medical provider should order surveillance lab tests every three months.

Billing for PrEP Initiation and Follow Up

Billing third-party payers for PrEP initiation visits can be billed in three different ways:

1. Office/outpatient facility submits a claim for a new or established E/M encounter with a billable provider (physician, APRN or PA) and all other services using appropriate CPT codes linked to the allowable ICD-10 diagnostic codes
2. Office/outpatient facility submits a claim for "Preventive Health Counseling" proved by a billable provider for patients who don't have an established diagnosed illness.
3. Office/outpatient facility submits a claim for a shared medical appointment provided by a billable provider and all services provided (not recommended)

PrEP Adherence Counseling

Once PrEP is initiated, patients should return for follow-up approximately every three months. Providers may wish to see patients more frequently at the beginning of PrEP to assess and confirm HIV-negative test status, assess for early side effects, discuss any difficulties with medication adherence, and answer questions. This must be performed by a licensed provider and be billed with the same codes as PrEP initiation. Use the E/M for new established patients (99201-99215) or preventive medicine counseling (99401-99412).

Counseling Z codes may also be added when a patient or family member receives assistance as the result of an illness or injury, or when support is required in coping with family or social problems. An example of this would be a visit for PrEP compliance but the patient may have also developed issues with housing.

Note: G0445 may be used for high-intensity counseling in primary care settings, but will have restrictions.

G0445 – High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes

The patient should be evaluated every three months for the following:

1. Repeated HIV testing and assessment for signs or symptoms of acute infection to document that the patients are still HIV-negative
2. Repeat pregnancy testing for women who may become pregnant
3. Provide a prescription or refill authorization for no more than 90 days
4. Assessment of medication side effects, compliance, and HIV-associated risk behaviors
5. Provide support for medication compliance and risk-reduction behaviors
6. Respond to new questions and provide any new information about PrEP
7. Conduct STI testing for sexually active persons with signs or symptoms of infection

Billing for Post-Exposure Prophylaxis[11]

Post-Exposure Prophylaxis (PEP) involves taking anti-HIV medications as soon as possible after potential exposure to HIV to try to reduce the chance of becoming HIV positive. These medications are designed to prevent HIV replication.

There are two types of PEP:

1. **Occupational PEP** (sometimes called "oPEP"), taken when someone working in a healthcare setting is potentially exposed to material infected with HIV.
2. **Non-occupational PEP** (sometimes called "nPEP"), which is more common, is taken after a potential exposure to HIV outside the workplace. Examples include following sexual assault, unprotected sex, or needle-sharing.

Occupational Post-exposure Prophylaxis (OPEP)

oPEP is recommended for health-care personnel (HCP) who have occupational exposure to blood or other body fluids that may contain human immunodeficiency virus. Such exposures

[11] https://www.hivguidelines.org/pep-for-hiv-prevention/occupational/

can occur when the individual receives a percutaneous injury (ex. needle stick injury), or comes into contact with mucous membranes or non-intact skin. The following body fluids are considered to be potential sources of infection[12]:

- Blood
- Semen and vaginal secretions
- Cerebrospinal fluid (CSF)
- Synovial fluid
- Pleural fluid
- Peritoneal fluid
- Amniotic fluid
- Pericardial fluid

When an employee suspects that they have been exposed to HIV, they must contact their Human Resources Department. Once a claim is filed, the date of injury is established and the employee is assigned a claim number. The employee is also assigned an adjuster who will coordinate the employee's care. The adjuster may authorize services from the employee's regular primary care provider, or the employee may be directed to receive services from the carrier's own network of providers. Often times, this is the healthcare worker's place of employment.

Workers' compensation claims are submitted using the CMS-1500 claim form; however they will not be submitted electronically. This is because workers' comp claims are submitted with a copy of the office notes that document the treatment that is described on the healthcare claim.

Healthcare workers who are suspected of having an occupational HIV exposure should be evaluated as soon as possible. PEP should be started within 72 hours of exposure. The average risk for HIV transmission after a percutaneous exposure to HIV-infected blood has been estimated to be approximately 0.3% (US Public Health, 2013). Situations that may potentially

[12] US Public Health Working Group; *Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis;* Infect Control Hosp Epidemiol 2013;34(9):875-892

increase the risk for seroconversion have been associated with exposure to larger amounts of infected blood. Examples include a situation is which a healthcare worker is exposed to a device that is visibly contaminated with blood, a procedure that involves a device being placed in a vessel, or a deep injury. Additionally, exposure to blood from a patient with a terminal illness is concerning. Occupational exposures to HIV should be considered urgent medical concerns and treated immediately. It is important to also consider the possibility that the source patient may also be infected with hepatitis, particularly hepatitis C (HCV).

Counseling for PEP

Counseling should occur at the time of exposure and with each follow up. The exposed individual should be advised to use precautions to prevent transmission. This includes the use of barrier contraception, avoiding blood donations, and avoiding breast feeding.

If the healthcare worker decides to receive PEP, the individual should be counseled on the following:

1) Potential drug toxicities and interactions that may mimic seroconversion
2) The need for adherence to PEP regimens
3) Early reevaluation after exposure

Regardless of whether or not PEP is prescribed, a follow up re-evaluation is suggested in 72 hours.

Testing Options for Source Patient

Whenever possible, the HIV status of the exposure source patient should be determined to guide appropriate use of HIV PEP. If the source patient is HIV-negative, then there are potential concerns that that individual may be in the window period. However, there have been no instances of occupational transmission like this in the US (US Public Health, 2013). Testing options for PEP are different than that for general recommended step-wise testing. It is generally recommended that routine HIV testing begin with a 4th generation immunoassay. In the case of occupational exposure, a more rapid test may be used because the results can guide the exposed individual as to whether or not they decide to initiate medical treatment.

Rapid HIV testing (CPT 86701) of source patients facilitates timely decision-making regarding the need for administration of HIV PEP after occupational exposures to sources whose HIV status is unknown. FDA-approved rapid tests can produce HIV test results within 30 minutes.

Third-generation chemiluminescent immunoassays (CPT 86703) can detect HIV specific antibodies 2 weeks sooner than conventional EIAs60 and generate test results in an hour or less.

Fourth-generation combination p24 antigen–HIV antibody (Ag/Ab) (CPT 87389) tests produce both rapid and accurate results, and their p24 antigen detection allows identification of most infections during the window period (US Public Health, 2013).

Administration of PEP should not be delayed while waiting for test results. If the source patient is determined to be HIV-negative, PEP should be discontinued, and no follow-up HIV testing for the exposed provider is indicated.

Stepwise Testing for the Exposed Individual (PrEP, oPEP, and nPEP)[13]

Individuals who experience an occupational exposure to HIV should be tested for HIV at baseline, then again at 6 weeks, 12 weeks, and 6 months. However, if the combination p24 antigen-antibody test is used, then testing can occur at baseline, 6 weeks, then 4 months after exposure.

The following sequential testing is recommended:

Step 1: HIV-1/2 Ag/Ab Combination Immunoassay (4th generation)

CPT CODE 87389

The Ag/Ab combination immunoassays will detect HIV-1 and HIV-2 Abs and HIV-1 p24 Ag, which is present during the acute stage before Ab seroconversion has occurred. As of March 2016, five FDA-approved 4th-generation HIV Ag/Ab combo immunoassays are available. Four of the five use technology that has been validated in combination with the recommended supplemental tests and are approved for use in step 1 of the recommended laboratory algorithm.

[13] US Public Health Working Group; *Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis;* Infect Control Hosp Epidemiol 2013;34(9):875-892

The four HIV Ag/Ab combo immunoassays that are acceptable for step 1 employ either enzyme immunoassay or chemiluminescent immunoassay technology and require the use of specific instrumentation to perform the test and/or read the results.

87389 – CLIA-waived test and must have **modifier QW** in order for it to be paid

36415 -Venipuncture for a non-rapid test

Step 2: HIV-1/2 Ab-Differentiation Immunoassay

CPT Code: 86701, 86702

If the initial screening result is reactive, the laboratory should test the specimen using an HIV-1/2 Ab-differentiation immunoassay that has been FDA-approved for use in the recommended algorithm. If the HIV-1/2 Ab-differentiation test is positive for HIV-1 Abs or HIV-2 Abs, the patient should be evaluated for a confirmed HIV-1 or HIV-2 infection. If the specimen is positive for HIV Abs but cannot be differentiated as HIV-1 or HIV-2, clinicians should proceed with medical evaluation for HIV infection.

Step 3: HIV-1 NATs for Diagnosis of Acute and Early HIV-1 Infection

CPT Code 87535

If the HIV-1/2 Ab-differentiation immunoassay is nonreactive or indeterminate, an HIV-1 RNA test should be performed immediately to confirm or exclude evidence of HIV infection.

Additional Lab Testing

Complete blood counts (CPT 85025), renal (CPT 80069), and hepatic function tests (CPT 80076) should be performed at baseline and 2 weeks after exposure if the individual chooses medication management.

OPEP Medications[14]

There are several options available for OPEP medications. The CDC recommends a four-week course of the following as the preferred medications:

Raltegravir (Isentress; RAL) 400 mg PO twice daily

Plus

Truvada, 1 PO once daily (Tenofovir DF [Viread; TDF] 300 mg emtricitabine [Emtriva; FTC] 200 mg)

Follow-Up Appointments

HCP who have experienced occupational exposure to HIV should receive follow-up counseling, post-exposure testing, and medical evaluation regardless of whether they take PEP. It is critical that the exposed individual be seen within 72 hours of exposure. This is an opportunity to ensure that the exposed individual has an appropriate understanding of the risks of seroconversion and the risks and benefits associated with medical intervention with PEP, and determine if ongoing treatment is even indicated. This is also an opportunity to emphasize the need of compliance, manage any side effects, and improve the likelihood of follow up testing. Additionally, it should be emphasized again the need for barrier contraception. It may be necessary to refer the HCP for psychological counseling.

It is recommended that follow up be expended for exposed workers who have become infected with HCV after exposure to a source who is co-infected with HIV and HCV. A person in whom HIV infection is identified should be referred to a specialist who has expertise in HIV treatment. Additionally, all cases of occupationally acquired HIV infection should be reported to the local health department.

Non-Occupational Post-Exposure Prophylaxis (nPEP)

Healthcare providers should consider recommending nPEP after patient exposures that carry a substantial risk for HIV infection. Efforts should be made to determine the HIV status of

[14]https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/post-exposure-prophylaxis

the patient and the source person (if available), and the timing, frequency and characteristics of the exposure. Additionally, health care providers should assess the likelihood of STIs, infections efficiently transmitted by injection practices or needle sticks (e.g., hepatitis B or hepatitis C virus), and pregnancy for women to determine whether other treatments may be indicated. [15]

Patients should only receive nPEP if they are HIV-negative. Therefore, routine HIV antibody testing should be performed on all persons seeking evaluation nPEP. If possible, this should be done with a rapid antibody or Ag/Ab blood test kit with results available within an hour. If this is not possible, then the patient should be started on HIV prophylactic medication and discontinued if it is later determined that the patient already has HIV. Repeat HIV testing should occur at 4–6 weeks and 3 months after exposure to determine if HIV infection has occurred. Testing protocol should follow that of oPEP.

All patients who are prescribed nPEP should have liver, renal and hematologic laboratory evaluations done routinely when indicated by the prescribing information for the antiretrovirals prescribed. The CDC recommends the following three drug combination for nPEP[16]:

Tenofovir DF 300 mg a

Plus

Fixed dose combination emtricitabine 200 mg (Truvadac) once daily

Plus

Raltegravir 400 mg twice daily or Dolutegravir 50 mg once daily

HIV Prevention Counseling for nPEP

Because nPEP is not 100% effective, patients should be advised to consistently use condoms or avoid needle sharing to reduce risks of contracting HIV and other STIs. This is particularly true throughout the nPEP treatment course. During follow-up visits, providers should assess the patients' needs for behavioral intervention, education, and services. This includes

[15] https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf
[16] https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

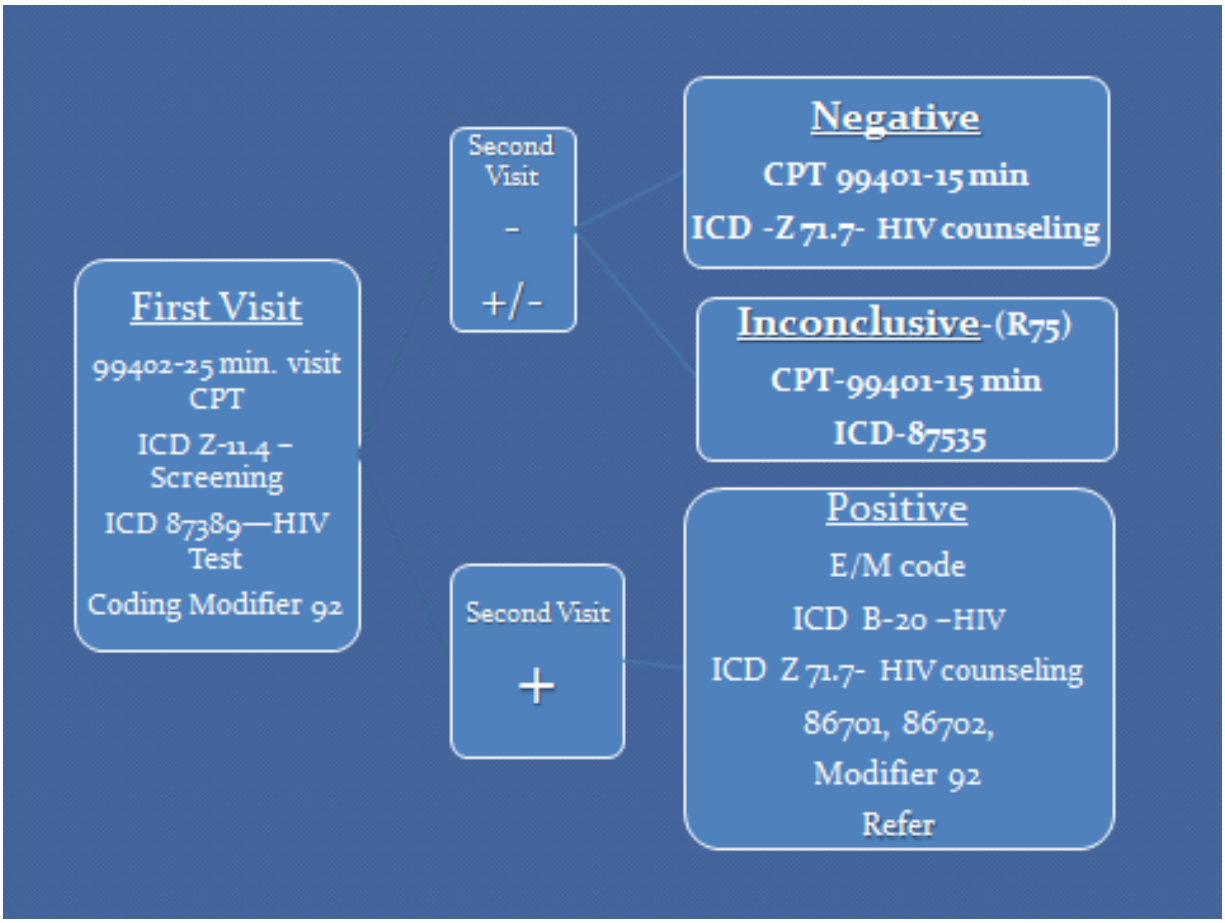
asking questions about sexual behaviors, alcohol use, and illicit drug use. It is the provider's responsibility to identify ongoing risk concerns and develop treatment plans which include suggestions for initiating protective behaviors. LHDs should become familiar with local resources for HIV education, behavioral risk reduction, counseling and support, inpatient and outpatient alcohol and drug-treatment services, family and mental health counseling services, and support programs for HIV-infected persons.

Conclusion

Because of recent changes in healthcare policies, and cuts in state and federal funding, LHDs and CBOs are now billing Medicaid, Medicare and private insurers for services related to HIV prevention. Most of the services are provided in traditional healthcare settings, however, some of these services are provided in non-traditional settings by non-licensed professionals. This makes it quite challenging to properly bill insurance for these services. This guide is designed to provide assistance for procedure and diagnosis codes that are accepted by third-party payers, and to assist LHDs and CBOs in overcoming challenges in obtaining reimbursement for HIV testing and related HIV prevention services.

Appendix 1

Flow-chart for HIV Testing



Appendix 2

HIV Billing Quick Reference Guide

Public Health Departments State of Illinois

HIV Testing

HIV tests can be performed and billed to any insurance company regardless if it is a Medicaid/MCO plan or a commercial/private plan. Medicare will not reimburse for any HIV services since the Public Health Department is only enrolled as a Roster Bill with Medicare.

Please note, if the county is collecting the specimen and sending it to an outside lab for processing then generally the lab will bill the patient for the test. In this case you will bill only the office visit and the venous lab draw charge. If the lab does not bill the patient directly and sends the testing bill to the county, then the county can bill for the lab CPT codes along with the office visit and lab draw.

- **HIV Screening Test**
  - **86703** HIV-1 and HIV-2, single result
    - Link to ICD 10 **Z11.4**

✓ When billing code 86703 to commercial/private insurances plans append **modifier 33**

  - **87389** HIV-1 antigens, with HIV-1 and HIV-2 antibodies, single result (ELISA)
    - Link to ICD 10 **Z11.4**

✓ 87389 is a CLIA waived test and must have **modifier QW** in order for it to be paid

  - **86689** HTLV or HIV antibody, confirmatory test (Western Blot)
    - Link to ICD 10 **Z11.4**

✓ When billing code 86703 to commercial/private insurances plans append **modifier 33**

✓ All three HIV tests above should be billed with venous lab draw code **36415**

✓ You can also bill an office visit with the HIV tests listed above, bill **99211** with **modifier 25.** *If the patient is being seen by a licensed health care professional such as a Physician, Nurse Practitioner or Physician's Assistant you can bill CPT code 99212*

- **HIV Counseling & Screening**

The following Preventative Medicine Counseling codes can be billed only if performed by either a physician, NP (Nurse Practitioner) or PA (Physician's Assistant).
Preventative medicine counseling and/or risk factor reduction interventions provided to individuals are codes that are based on time that is spent face to face with the patient.

  - **99401** approximately 15 minutes
  - **99402** approximately 35 minutes
  - **99403** approximately 45 minutes
  - **99404** approximately 60 minutes

If the patient is being seen by a RN or other non-licensed staff, then the following can be billed:

  - **98960** Self-management education and training face to face, 1 patient
    - HIV counseling codes should be linked to ICD 10 **Z71.7**
    - High Risk Sexual Behavior should be linked to ICD 10 **Z72.51**

✓ Do not use modifier 33 on CPT codes 99401-99404 or 98960

- **Pre-Exposure Counseling (PrEP)**

The following CPT codes should be used for Pre-Exposure Counseling only if performed by either a physician, NP (Nurse Practitioner) or PA (Physician's Assistant).
Pre-Exposure Counseling provided to individuals are codes that are based on time that is spent face to face with the patient.

- **99401** approximately 15 minutes
- **99402** approximately 35 minutes
- **99403** approximately 45 minutes
- **99404** approximately 60 minutes

If the patient is being seen by a RN or other non-licensed staff, then the following can be billed:

- **98960** Self-management education and training face to face, 1 patient
    - Pre-Exposure Counseling codes should be linked to ICD 10 **Z20.2**

Please note that diagnosis code ICD 10 B20 should not be used unless the patient has been previously diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome). Once this code has been appended to a patient's medical record it is not easily removed.

Written by Stephanie Moseman, CPC

Appendix 3

STD Billing Quick Reference Guide

Public Health Departments State of Illinois

STD Testing

STD tests can be performed and billed to any insurance company regardless if it is a Medicaid/MCO plan or a commercial/private plan. Medicare will not reimburse for any STD services since the Public Health Department is only enrolled as a Roster Bill with Medicare.

Please note, if the county is collecting the specimen and sending it to an outside lab for processing then generally the lab will bill the patient for the test. In this case you will bill only the office visit and the venous lab draw charge. If the lab does not bill the patient directly and sends the testing bill to the county, then the county can bill for the lab CPT codes along with the office visit and lab draw.

*All STD tests listed below can be billed with an office visit CPT code **99211**. If the test being performed also includes a blood draw charge, then you must append **modifier 25 to CPT code 99211**.*

- **Chlamydia**
  - **87491** Infectious disease agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, amplified probe technique. Urine or Swab
  - **87110** Culture, chlamydia, any source
    - Link to ICD 10 **Z11.3 or 20.2**

- **Gonorrhea**
  - **87591** Infectious disease agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, amplified probe technique. Urine or Swab
    - Link to ICD 10 **Z11.3 or Z20.2**

- **Syphilis**
  - **86592** Syphilis test, non-treponemal antibody; qualitative (eg VDRL, RPR. ART)
  - **86593** Syphilis test, non-troponemal antibody; quantitative
  - **86780** Treponema pallidum
    - Link to ICD 10 **Z11.3 or Z20.2**
  - ➢ The syphilis tests listed above are blood tests that should be billed with a venous lab draw code 36415

- **Herpes**
  - **86695** HSV 1 IgM, Swab
  - **86696** HSV 1 IgM, Swab
    - Link to ICD 10 **Z11.3 or Z20.2**

- **Hepatitis C**
    - **86803** Hepatitis C surface antigen, rapid test
        - Link to ICD 10 **Z11.3 or Z20.2**
    - ➢ The Hepatitis C test listed above is a blood test that should be billed with a venous lab draw code 36415

- **STD Counseling & Screening**

The following Preventative Medicine Counseling codes can be billed only if performed by either a physician, NP (Nurse Practitioner) or PA (Physician's Assistant).
Preventative medicine counseling and/or risk factor reduction interventions provided to individuals are codes that are based on time that is spent face to face with the patient.

- **99401** approximately 15 minutes
- **99402** approximately 35 minutes
- **99403** approximately 45 minutes
- **99404** approximately 60 minutes

If the patient is being seen by a RN or other non-licensed staff, then the following can be billed:

- **98960** Self-management education and training face to face, 1 patient
    - STD counseling codes should be linked to ICD 10 **Z11.3 or Z20.2**
    - High Risk Sexual Behavior should be linked to ICD 10 **Z72.51**

✓ Do not use modifier 33 on CPT codes 99401-99404 or 98960

- **Pre-Exposure Counseling (PrEP)**

The following CPT codes should be used for Pre-Exposure Counseling only if performed by either a physician, NP (Nurse Practitioner) or PA (Physician's Assistant).
Pre-Exposure Counseling provided to individuals are codes that are based on time that is spent face to face with the patient.

- **99401** approximately 15 minutes
- **99402** approximately 35 minutes
- **99403** approximately 45 minutes
- **99404** approximately 60 minutes

If the patient is being seen by a RN or other non-licensed staff, then the following can be billed:

- **98960** Self-management education and training face to face, 1 patient
    - Pre-Exposure Counseling codes should be linked to ICD 10 **Z20.2**

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