NASTAD

Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), and Other HIV Prevention Strategies

Billing and Coding Guide

October 2023

Disclaimer

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Introduction

Health department HIV prevention programs, and the providers they support, offer a range of vital prevention services—including HIV pre-exposure prophylaxis (PrEP) services, post-exposure prophylaxis (PEP) services, linkage to care services, adherence counseling, and HIV testing. Some of these services are performed by physicians, advanced practice registered nurses (APRN), physician assistants (PAs), or the staff working under the supervision of these medical professionals. As an alternative, some of these same services are provided by community health workers (CHWs) or other non-licensed health professionals and peers.[1] Payment by public and private payers for these services can be problematic, depending upon how the payer (e.g., Medicare, Medicaid, or private insurance plans) wants the service reported, the credentials of the person providing the service, and the setting in which the service is provided. As a result of the Affordable Care Act (ACA), the percentage of uninsured patients has decreased (especially in states with Medicaid expansion[2]). Sites performing these services – including public health departments – are strongly encouraged to bill patients' insurance for reimbursement for these important services to preserve scarce funding for services and individuals not covered by public and private insurance. While some of the services are provided in traditional healthcare settings (i.e., clinics and community health centers) and can be billed to public and private insurance, some of these services are provided in non-traditional settings, including via telehealth, by non-licensed professionals making it a challenge to bill insurance for these services.

Health departments and other medical providers are billing Medicaid, Medicare, and private insurers for services related to HIV prevention. The counseling services needed for the treatment and discussion of lab tests are intensive. This guide describes the procedure and diagnosis codes that are accepted by public and private insurance, along with specific requirements for some Current Procedural Terminology (CPT®) billing codes. It also describes some of the challenges in obtaining reimbursement for testing, counseling, linkage to care, and adherence services.

How to best use this guide

The goal of this billing and coding guide is to provide up-to-date information and best practices for coding, billing, and denial resolution for PrEP and PEP services. The intention is that this guide will serve as a foundation from which a healthcare organization can build internal PrEP and PEP coding and billing policies. The ACA coverage mandate for PrEP and other preventive services is national and applies to all non-grandfathered plans and Medicaid expansion benefits.[3] However, because there is not a uniform way PrEP encounters play out, there is also not a uniform billing and coding playbook for getting these

[1]In 2013, the Centers for Medicare and Medicaid Services (CMS) amended federal preventive services Medicaid regulations to allow CHWs and other non-licensed providers to provide preventive services and have those services paid by state Medicaid programs when the services are recommended by a physician or other licensed provider. However, the state Medicaid program department must apply to CMS to be able to do this. CMS Center for Medicaid and CHIP Services Bulletin, Update on Preventive Services Initiatives, available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf

[2]At the time of this publication (October 2023) 40 states have expanded Medicaid either traditionally or through an 1115 Waiver. See the status of each state here https://www.commonwealthfund.org/blog/2022/where-do-states-stand-medicaid-expansion

[3]The ACA preventive services coverage and cost-sharing requirements do not apply to Medicare or to traditional Medicaid programs.

encounters paid. Even when closely following the Centers for Disease Control and Prevention (CDC) guidelines for PrEP[4], the services provided during a PrEP visit may vary depending on patient and provider decision-making and individual patient needs and medical history. Payers also have a great deal of discretion in setting their own guidelines for the circumstances under which they will pay for services. All of these variations impact the ability to standardize the coding and billing for these services. This guide includes descriptions of scenarios for PrEP initiation and follow-up visits for adherence, linkage, counseling services, and for lab tests for HIV and other STIs. It addresses CPT® codes and diagnosis codes that could be reported to the patient's insurance company or a government payer.

It will also include who may provide this service either directly or under the supervision of a licensed professional. Unfortunately, there are many services provided by HIV and other public health program staff members that are either not described by a CPT® code, or not performed by a healthcare professional who is credentialed by an insurance company. This limits the ability to seek reimbursement from the insurer for the service rendered by those unenrolled professionals.

What has changed since the 2016 guide?

There have been many changes in the HIV Prevention environment since the 2016 edition of the guide. The changes encompass clinical, insurance coverage, coding and billing, and published documentation.

FDA approved second oral PrEP medication

In 2012, TDF/FTC, (Truvada®) was the first FDA-approved medication for use in HIV prevention.

In 2019, the FDA approved the second drug, TAF/FTC, (Descovy®), to prevent HIV infection.[5]

In 2020, the FDA approved the generic version of TDF/FTC for commercialization. (PrEP Generics Entering the US Market: FAQs)

FDA approval of Cabotegravir extended-release injectable suspension, a long-acting injectable PrEP option

In 2021, the FDA approved the first injectable treatment for HIV prevention.[6] Cabotegravir extended-release injectable suspension (Apretude®) was approved for PrEP.

USPSTF A Grade

In August 2023, the United States Preventive Services Task Force (USPSTF) published an updated recommendation statement which "recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons at increased risk of HIV acquisition to decrease the risk of acquiring HIV.", granting an "A" Grade recommendation.[7] This recommendation replaces but is consistent with the June 2019 USPSTF granting of PrEP as an "A" grade recommendation. For the current recommendation, the USPSTF reviewed additional evidence on new formulations of PrEP that were approved by the FDA after 2019, including TAF/FTC and long-acting injectable cabotegravir. The services

[4]CDC Pre-Exposure Prophylaxis for the Prevention of HIV Infection – 2021 UPDATE https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

[5]FDA approves second drug to prevent HIV infection as part of ongoing efforts to end the HIV epidemic https://www.fda.gov/news-events/press-announcements/fda-approves-second-drug-prevent-hiv-infection-part-ongoing-efforts-end-hiv-epidemic

[6]FDA Approves First Injectable Treatment for HIV Pre-Exposure Prevention https://www.fda.gov/news-events/press-announcements/fda-approves-first-injectable-treatment-hiv-pre-exposure-prevention

[7]Preexposure Prophylaxis to Prevent Acquisition of HIV US Preventive Services Task Force Recommendation Statement https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis

[8]NASTAD PrEP Coverage Brief: PrEP Services Covered with No Cost-Sharing https://nastad.org/sites/default/files/2021-12/PDF-PrEP-Coverage-Brief.pdf

covered within the scope of this recommendation include regular provider visits, testing for HIV, testing for STIs, Hepatitis B, Hepatitis C, and monitoring lipids and kidney function. Through the ACA, all non-grandfathered commercial and governmental payers must fully cover these A and B grade preventive services without cost-sharing.[8]

Departments of Health and Human Services, Labor, and Treasury Guidance
In July 2021, the Departments of Health and Human Services, Labor, and Treasury issued guidance for plans on the implementation of the ACA coverage and cost-sharing requirements for PrEP.[9] The guidance clarifies that in addition to providing access to the PrEP medication without cost sharing, plans also must cover the following ancillary services without cost sharing:

- HIV testing (at initiation and every three months)
- Hepatitis B and C testing (at initiation and periodically consistent with CDC guidelines)
- Creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR) (at initiation and periodically consistent with CDC guidelines)
- Sexually transmitted infection screening and counseling (at initiation and periodically consistent with CDC guidelines, including three-site anatomic testing for gonorrhea and chlamydia and testing for syphilis, together with behavioral counseling)
- Adherence counseling (at initiation and regularly consistent with CDC guidelines)
- Office visits associated with each recommended preventive service when the primary purpose of the office visit is the delivery of the recommended preventive service.

HCPCS code
HCPCS Code J0739, Injection, cabotegravir, 1 mg was issued effective July 1, 2022. This code is used to report a 1 mg injection of Apretude.

ICD-10-CM Code
The ICD-10-CM code set effective for dates of service on or after 10/1/2023 includes Z29.81 - Encounter for HIV pre-exposure prophylaxis. ICD-10 code Z29.81 will be used as the primary diagnosis code on PrEP claims to facilitate the accurate processing of PrEP claims. Some payers may require ICD-10 codes that differ by plan. The creation of this new code may mitigate variance across plans for PrEP claims. Using this code in the primary position may help ensure that the claim is properly routed through the payer adjudication system. This code will identify the claim as preventive and processed without patient cost-share.

Z29.81 Encounter for HIV pre-exposure prophylaxis

Code also, if applicable, risk factors for HIV, such as:

- Contact with and (suspected) exposure to human immunodeficiency virus [HIV] (Z20.6)
- High risk sexual behavior (Z72.5-) *This code reference is included here as it is a part of the official ICD-10 instruction. Due to the stigmatizing language in this range of codes Z72.5X providers and patients tend to avoid these codes. However, some payers may require these codes for reimbursement.*

[9]Departments of Health and Human Services, Labor and the Treasury, FAQs about ACA Implementation Part 47 (July 19, 2021), available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf

CDC Provider Publications
In 2021 the CDC updated two publications regarding PrEP. According to the CDC, the **Clinical Practice Guidelines**[10] update "… are intended to update existing guidance using the current evidence base, to incorporate recent FDA PrEP medication approvals, and to clarify specific aspects of clinical care. Other revisions were made to improve usability and increase implementation of the guideline based on comments received from clinicians providing PrEP care…"

In addition, the CDC also updated **CDC Clinical Provider Supplement**[11]. According to the CDC, "These revisions are intended solely to update the developing evidence base and to clarify specific points in clinical care."

[10]Preexposure Prophylaxis for The Prevention of HIV Infection In The United States– 2021 Update A Clinical Practice Guideline https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

[11]Preexposure Prophylaxis for The Prevention of HIV Infection in The United States – 2021 Update Clinical Providers' Supplement https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-provider-supplement-2021.pdf

II.

Codes and Coding for Services

Several sets of codes were developed to translate healthcare services, diagnoses, procedures, equipment, and supplies into a standard alphanumeric language used to communicate between providers and payers. This section describes these codes.

CPT® Codes (Current Procedural Terminology)

The American Medical Association (AMA) develops these CPT® codes to describe services performed by healthcare providers.[12] Individual insurance companies (payers) and state Medicaid programs are free to develop a set of reimbursement and payment guidelines for these codes but cannot create proprietary codes or alter CPT® codes or descriptions. Payers are not required to cover all services described by a CPT® code. These codes are 5-digit numeric codes. CPT® codes are commonly referred to as "procedure codes".

HCPCS Codes (pronounced hick-picks)

Healthcare Common Procedure Coding System (HCPCS): Centers for Medicare and Medicaid Services (CMS) issues and maintains HCPCS codes through its HCPCS Workgroup.[13] These codes typically describe non-physician services. They represent products, supplies, devices, services, and drugs/biologicals. Many supplies used in the course of professional services are included in the payment for that service. However, drugs that are not typically self-administered may be billed separately. These are commonly referred to as "HCPCS codes". HCPCS codes are 5-character alpha-numeric codes. HCPCS is composed of a single alpha (A-V), followed by 4 numeric digits.

The two main categories of codes that will be referenced in this guide are G codes and J codes. G codes are typically temporary codes that describe professional services that do not have an assigned CPT® code yet. If a CPT code exists that describes the service, the CPT code should be reported. J Codes describe generic and specific drug products. CMS maintains place of service (POS) codes used throughout the healthcare industry.[14]

ICD-10 Codes (International Classification of Diseases – 10th Revision)

The World Health Organization (WHO) developed ICD codes as a basis for comparable global statistics on causes of mortality and morbidity. In the US, this code set has developed a clinical modification (CM) for use in describing the signs, symptoms, illnesses, injuries, or other reasons that cause a patient to

[12]The CPT® coding system offers doctors across the country a uniform process for coding medical services that streamlines reporting and increases accuracy and efficiency. For more than 5 decades, physicians and other healthcare professionals have relied on CPT to communicate with colleagues, patients, hospitals, and insurers about the procedures they have performed. CPT® purpose & mission | American Medical Association

[13]CMS has a comprehensive process for issuing new HCPCS codes. HCPCS codes are updated quarterly.

[14]The most recent update to the Place of Service code set was in June 2023 https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set

encounter healthcare.[15] These codes are used in conjunction with CPT® codes to describe the reason for the services provided. These are commonly referred to as "diagnosis codes".

Payers require that all services are medically necessary. ICD-10 codes are used to convey that the reasons for the services provided are an accepted standard of medical practice. A practice or health department could provide a service that is covered, and described by a CPT® code, but not have the diagnosis code that the payer will allow and pay. In that case, the service will be denied.

Modifiers

There are two sets of modifiers. CPT® Modifiers are two-digit numerical codes created by the AMA. HCPCS modifiers are two-character alpha or alpha-numeric codes created and maintained by CMS.

Both sets of modifiers provide the means to communicate that the service (CPT® code) provided has been altered by some specific circumstance but the essence of the base CPT® code has not changed. Modifiers are most often used to communicate an increased or reduced service or that a specific set of circumstances existed at the time of service that will cause the service to be covered under published payment policy guidelines. Multiple modifiers may be used to qualify a single CPT® code.

MODIFIER EXAMPLE #1

CPT®	Modifier	ICD-10
99401	33	Z20.6
Approximately 15 minutes were spent with the patient providing preventive medicine counseling	rendering a USPSTF Grade A preventive service	because the patient had contact with or suspected exposure to HIV.

MODIFIER EXAMPLE #2

CPT®	Modifier	Modifier	ICD-10
99402	95	33	Z20.6
Approximately 30 minutes were spent with the patient providing preventive medicine counseling	rendered as a telemedicine service	rendering a USPSTF Grade A preventive service	because the patient had contact with or suspected exposure to HIV.

Place of Service Codes

POS codes are two-digit codes reported on claims to identify the setting in which the service was provided. The POS code is not selected by the provider but systematically identified by the clinic or practice location for which the appointment was created. This code set is critical to accurately reporting non-traditional settings for healthcare delivery.

[15] ICD classification is owned, copyrighted, and published by the World Health Organization. The National Center for Health Statistics developed the clinical modification (ICD-10-CM) for the purposes of classifying morbidities.

Two POS codes have been updated since 2022 and one was added in 2023.

Code	Name	Description
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
27	Outreach Site/ Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals. (Effective October 1, 2023)

Relationship among CPT®, ICD, HCPCS, and modifier codes

The combination of all of these code types is used to accurately describe the service(s) that were provided during an encounter. The codes must work in concert. If the codes are not congruous, then the service described on the claim will not likely be met with approval by the payer.

- CPT® codes describe **what** was done.
- ICD-10 codes describe **why** the service was performed.
- Modifiers provide **additional information** not described by another CPT® code
- HCPCS codes describe what **supplies** were used to complete the service.
- POS codes describe **where** the service was performed.

Payment and Relative Value Units[16]

Services are paid based on a fee associated with each CPT® or HCPCS on a fee-for-service claim. There are no payment amounts assigned to ICD-10 codes or to Modifiers. Each payer assigns its own payment amount. However, many payers use Relative Value Units (RVUs) as a basis for determining the allowable amount for each service. The RVU is an economic value assigned to CPT® codes that represents the relative cost of providing each service. The RVU system is complex. The formula that CMS uses to calculate payment amounts includes physician work, practice expense, liability expense, and geographic expense. RVUs apply to professional services only. They do not apply to laboratory services, equipment, or supplies.

[16]The Resource Based Relative Value Scale (RBRVS) from 1992 is the basis for the current RVU system. The AMA's Specialty Society RVS Update Committee (RUC) evaluates value updates to existing codes and recommends values for new codes. The RUC provides recommendations but does not determine Medicare pricing.

As a general rule of thumb and for the purposes of this guide, Work RVUs (WRVUs) are a good benchmark to compare values among code choices. While the WRVU by itself cannot be used to determine a payment amount, it allows the provider a sense of the relative value of one code to another.

Works RVUs for Evaluation & Management (E&M) Codes

CPT® New Patient	WRVU	CPT® Established Patient	WRVU
		99211	0.18
99202	0.93	99212	0.70
99203	1.60	99213	1.30
99204	2.60	99214	1.92
99205	3.50	99215	2.80

Work RVUs for Preventive Medicine

Age Range	CPT® New Patient	WRVU	CPT® Established Patient	WRVU
12-17 years	99384	2.00	99394	1.70
18-39 years	99385	1.92*	99395	1.75
40-64 years	99386	2.33	99396	1.90
65 and over	99387	2.50	99397	2.00

*The WRVU typically increases with the age of the patient. For code 99385, the WRVU decreases. Although unexpected, this value has been validated with the CMS RVU files.

Work RVUs for Preventive Medicine Counselinge

CPT® Code	Time	WRVU
99401	15-29 minutes	0.48
99402	30-44 minutes	0.98
99403	45-59 minutes	1.46
99404	60 or more minutes	1.95

For other provider types like Federally Qualified Health Centers (FQHCs), a set of services will be reimbursed at a bundled encounter rate instead of based on fee-for-service (FFS). This bundled payment may cover multiple professional services provided to a patient at a single location on a single date of service. The coding for the services remains the same as with FFS providers.

Providers Permitted to Provide Services

Insurance companies pay for services that are described by a CPT® code and performed by a licensed and enrolled practitioner or for work performed under the supervision of a licensed practitioner. Licensing requirements vary from state to state[17]. Enrollment and supervision requirements vary from payer to payer. Compliance with licensing, supervision, and enrollment requirements is the responsibility of the organization in which the service is performed.

In summary, a group or a provider may only be paid by an insurance company or government payer for services that are:

- Described by a CPT® code, or a HCPCS code, and considered covered and payable by the payer as described in the payer published policy
- Performed by a licensed provider or under the supervision of a licensed provider
- Supported by a covered diagnosis code, if required by the payer policy
- All modifier, POS code, or other information required by the payer published policy is present on the claim.

[17]In 2013, the Centers for Medicare and Medicaid Services (CMS) amended federal preventive services Medicaid regulations to allow community health workers and other non-licensed providers to provide preventive services and have those services paid by state Medicaid programs when they are recommended by a physician or other licensed provider. However, the state Medicaid program department must apply to CMS to be able to do this. In addition to the preventive services CMS rule change, there are several CMS authorities that states have successfully used to cover services provided by community health workers, peers, and other non-licensed providers.

III.

Obstacles to Payment or Accurate Adjudication

The step in the revenue cycle that can create the greatest economic loss to the provider and the patient is third-party follow-up. Third-party follow-up is a role in the billing department that investigates unpaid, denied, or inappropriately processed claims with payers. The intention of this function is to correct claims and have the payer reprocess them accurately.

Denials

The goal is always to submit a claim that will be paid and processed appropriately at first submission. However, denials will occur for even the most meticulous Revenue Cycle Management (RCM) team. Denials occur when no payment is made to the provider. These claims are easily identified in the payment processing phase of the revenue cycle. The payer is required to identify the reason for the denial and provide detail with nationally standardized reason codes.[18] The claims resolution staff can evaluate these reason codes, identify the payer policy creating the denial, and correct the claim. Following a denial review, information on how to appropriately code each encounter can be fed back to the front end, the provider, the coders, or the RCM team, to alter the initial submission and avoid denials in the future.

Paid but Erroneously Processed Claims

The more difficult claims to isolate and address are ones that have been paid, but have been processed incorrectly, i.e., claims that apply an incorrect patient cost share or include payment for only one unit of a multi-unit procedure. It is critical that the RCM team identifies a method of systematically flagging these erroneously processed claims. For PrEP claims, this can happen when the encounter is processed as diagnostic instead of preventive or when one of the lab tests provided as part of the encounter is denied, but others are paid. For the purposes of this guide, we recommend creating a way to identify ACA-covered preventive services in the billing system to ensure that these claims are paid and processed with no patient cost share. The addition of the new PrEP ICD-10 code will be invaluable in the identification of these claims for providers, billers, and payers.

Payers and Medical Policies

Another obstacle to inaccurately processed claims is payer-specific medical policies. Medical policies are plan documents created and published by a payer that provide guidelines for determining criteria for coverage of specific healthcare services. While each non-grandfathered plan must cover ACA-mandated preventive services, each payer has the right to create its own medical policy that can have an enormous influence on how the service is covered. For instance, medical policies may include utilization management and prior authorization criteria for the PrEP medication component or limitations on the intervals that certain lab and ancillary services will be covered.

[18]X12, chartered by the American National Standards Institute for more than 40 years, develops and maintains EDI standards including Claim adjustment Group codes, Claim Adjustment Reason Codes, and Remittance Advice Remark Codes

Individual insurance companies, state Medicaid programs, and CMS may independently develop a set of reimbursement and payment guidelines. Because each health insurance carrier builds payer and plan-specific documents, there may be different criteria for a clean and payable claim for the same service. It is critical that the billing department, particularly the claims resolution team has access to any published medical policy for the payers with which the provider is enrolled. These medical policies will play a significant role in submitting payable claims and appealing inappropriately processed claims. This means that claims for the same service might be coded differently depending on the payer.
Medical Policies typically include;

- Benefit name
- Plans or states for which the policy is applicable
- A description of the services and applicable definitions
- Demographic information of covered members, i.e., gender, age
- The frequency with which the payer will pay for the service
- CPT codes that represent the covered service
- Medical necessity criteria
  - Medical conditions which must exist and be reported for coverage
  - ICD-10 codes that define covered conditions or reasons for the service
- Any applicable modifiers and the manner in which they should be applied

HCPCS G Codes

HCPCS G codes are not inherently obstacles to payment, but they can present challenges. HCPCS codes are issued and maintained by CMS and typically apply to Medicare. In this guide, the G codes referenced will be the codes pertinent to PrEP and PEP services. From a billing perspective, G codes are typically temporary codes that describe professional services that do not have an assigned CPT code yet. G codes are initially created for Medicare use. However, other payers have adopted these codes to represent services covered within their medical policies.

With legislation over the last three decades, Medicare has shifted from covering very few preventive services to covering many preventive services that are evidenced-based and recommended by the USPSTF. In order for CMS to add these services to Medicare coverage, Medicare has developed National Coverage Determinations (NCDs) to specify circumstances for coverage for a specific medical or preventive service to be covered by Medicare Part B. NCDs are Medicare's medical policy publications. However, unlike other payers, Medicare can create, issue, and publish HCPCS codes for a specific benefit.

The AMA published CPT Preventive Medicine Services codes in 1994: CPT Codes 99381-99397. These CPT codes represent the age and gender-appropriate history, exam, counseling, risk factor reduction, and interventions. Based on clinical data, CMS determined that these CPT codes did not accurately reflect the services their preventive benefit category would cover.

Medicare issued Preventive Services G codes. The codes below are a sample of the G codes used by Medicare to represent covered preventive services.

HCPCS	Description
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
Q0091	Screening pap smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate-specific antigen test (PSA)
G0104	Colorectal cancer screening; flexible sigmoidoscopy

This narrowly defined preventive services code set is not an obstacle to payment per se, but it provides a level of complication that requires attention. Providers, coders, and billers must understand and apply these codes in order to be paid by Medicare. There is no one-to-one mapping from CPT to these G codes. Challenges can arise when non-Medicare payers adopt these codes to define their medical policy.

CPT codes that represent Preventive Counseling are not covered by Medicare. At the time of publication (October 2023), CMS had not published a final NCD regarding PrEP. However, the CMS process for the publication of an NCD is at the National Coverage Analysis (NCA)[19] phase of the process. It is expected to be finalized shortly. Supplemental materials will be shared. The latest CMS coverage documents can be found in the Medicare Coverage Database (MCD).[20]

What services and what plans are subject to the ACA preventive services coverage mandates?

Some payers are often quick to mention the following false statements

1. They are not subject to the ACA preventive services requirements, because they are self-insured or self-funded.
2. Services that we know to be USPSTF Grade A or B services are not covered benefits for their plans.
3. The members are liable for co-pays or co-insurance for these USPSTF Grade A preventive services.

None of the above statements are true.

Preventive services covered under ACA

1. The ACA mandated coverage without patient cost share for three categories of preventive services: USPSTF Grade A & B preventive services
2. Preventive Care for women and children
3. Vaccines for children and adults

The USPSTF has determined that PrEP for the prevention of HIV infection is evidence-based and has been granted a Grade A. Therefore, PrEP must be covered without patient cost-share, which includes co-pays, co-insurance, and deductibles.

Plans Subject to ACA Essential Health Benefits

Due to PrEP's USPSTF Grade A rating, all PrEP services are subject to the ACA's Essential Health Benefits requirements, including the preventive services coverage and cost-sharing provisions codified at 42 USC §300gg–13 and 29 CFR § 2590.715-2713. Under these provisions, individual and non-grandfathered group health plans are required to cover services with a Grade A or B from the USPSTF without cost sharing, starting no later than the plan year beginning one year after the final recommendation.

A grandfathered plan[21] is an individual health insurance policy purchased on or before March 23, 2010. Plans may lose "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose whether it considers itself a grandfathered plan.

[19]CMS National Coverage Analysis (NCA: Preexposure Prophylaxis (PrEP) Using Antiretroviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=310

[20]Search the Medicare Coverage Database for PrEP coverage updates. Use the search term Preexposure https://www.cms.gov/medicare-coverage-database/search.aspx

[21]HealthCare.gov Grandfathered health plans https://www.healthcare.gov/glossary/grandfathered-health-plan/

The following plans, created and not significantly altered since March 23, 2010, are subject to the ACA preventive services protections. That is, they are required to follow the ACA zero cost-share provisions.

- Qualified Health Plan (QHP) sold in the marketplace
- Self-funded non-federal government plan (e.g., a plan offered by a municipality)
- Self-funded employer plan
- Large group employer plan (fully insured)
- Small group employer plan (fully insured)

In addition, the ACA preventive services coverage and cost-sharing requirements apply to Medicaid expansion benefits. These protections, however, do not apply to traditional Medicaid programs (though states may choose to adopt this plan design for traditional Medicaid eligibility groups) or to Medicare (as discussed above, Medicare has separate preventive services requirements).

Many states have also enacted state-level protections that shield consumers from cost sharing for preventive services that may go further than the federal preventive services requirements. These state laws will apply to a smaller swath of the insurance market (individual and fully insured group plans), but may be an important protection.[22]

Use these facts about federal and state laws to overturn denials and erroneously processed claims.

[22]Commonwealth Fund, The ACA's Preventive Services Benefit Is in Jeopardy: What Can States Do to Preserve Access? https://www.commonwealthfund.org/blog/2022/aca-preventive-services-benefit-jeopardy-what-can-states-do

IV.

ICD-10-CM Diagnosis codes for HIV Prevention

Diagnosis Codes for PrEP Related Services

The codes in this section apply to PrEP visits, PrEP lab services, and all TelePrEP services. A list of relevant diagnosis codes is at the end of this guide. Additionally, providers should reference the full ICD-10 publication to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding system has designated a specific diagnosis code for PrEP and related services. All services require a primary diagnosis code to indicate the primary reason for the service. Additional codes may be required or necessary to convey all the reasons for the service provided.

"Contact with" and "Exposure to" codes are not recommended as they indicate a post-exposure condition. However, ICD-10-CM includes reference to "contact with and suspected exposure to" codes in the official notations as codes that may be reported additionally to fully describe the patient condition. Payers may also require these codes as indicated in published medical policy. Therefore, these codes are included, though not recommended.

Based on the 2024 ICD-10 guidelines for the use of this newly designated code, the codes below are recommended for use in reporting PrEP-related services.

Per 2024 ICD-10-CM Guidelines: *[Effective 10/01/2023]*[23]

1. Report Z29.81 Encounter for HIV pre-exposure prophylaxis in the first position for each service rendered or ordered as a part of the PrEP protocol.
2. Report appropriate screening ICD-10 code specific for the tests ordered or provided.

Code also if applicable, risk factors for HIV, such as:

3. contact with and (suspected) exposure to human immunodeficiency virus [HIV] (Z20.6)
4. high-risk sexual behavior (Z72.5-) *This code reference is included here as it is a part of the official ICD-10 instruction. Due to the stigmatizing language in this range of codes Z72.5X, providers attempt to avoid these codes. However, some payers may require these codes for reimbursement.*

This is a list of the most commonly used ICD-10 codes for the PrEP-related visit and lab tests listed in this guide. This list of codes was gathered from standard coding conventions and payer policy. Other payer policies may require additional or other screening ICD-10 codes to support payer-specific medical necessity requirements.

Not all the ICD-10 codes listed below should be used for every service. ICD-10 codes are assigned to support medical necessity of the service. For a visit, reporting only Z29.81 may be sufficient based on payer policy. However, because ICD-10 codes exist for each specific disease or disease category, lab

[23] ICD10-CM 2024 Guideline for new code Z29.81 Encounter for HIV pre-exposure prophylaxis; Code also, if applicable, risk factors for HIV, such as: contact with and (suspected) exposure to human immunodeficiency virus [HIV] (Z20.6) or high-risk sexual behavior (Z72.5-)

services will require both the Z29.81 and codes for the specific screening laboratory services.[24] While there are general screening codes, there are also more specific codes for screening that are required by most payers for specific tests and conditions.

See Appendix and the ICD-10 Complete Official Codebook for additional ICD-10 codes

Z29.81 will be the primary ICD-10 code for all PrEP claims. Codes included on the claim subsequent to the Z29.81, are reported in the order of pertinence to the encounter.

ICD-10 Code	Description	Use For
Z29.81	**Encounter for HIV pre-exposure prophylaxis**	**Primary for all PrEP services**
Z01.812	Encounter for preprocedural laboratory examination	Use for urine and blood test before initiation
Z01.812	Encounter for preprocedural laboratory examination	Use for blood or urine tests before treatment.
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission	STI screening
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]	HIV screening
Z11.59	Encounter for screening for other viral diseases	
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.5	Contact with and (suspected) exposure to viral hepatitis	
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
Z79.899	Other long term (current) drug therapy	PrEP monitoring
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11 series indicated below.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.

[24]CMS NCD for HIV screening requires Increased risk factors not reported: Z11.4;Increased risk factors reported: Z11.4 and Z72.51, Z72.52, Z72.53, or Z72.89; Pregnant patients: Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93

The following codes are included for completeness only. The codes above are typically sufficient and avoid the use of the Z72.x codes that providers and patients find stigmatizing because of the language used. However, some payers may require these codes for reimbursement.		
Z72.51	High-risk heterosexual behavior	HIV, STI screening
Z72.52	High-risk homosexual behavior	HIV, STI screening
Z72.53	High-risk bisexual behavior	HIV, STI screening
Z72.89	Other problems related to lifestyle	Use for drug-seeking behavior or unhealthy drinking behavior
Opioid abuse --no specific code for IV use		
F11.10	Opioid abuse, uncomplicated	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.90	Opioid use, uncomplicated	
Pregnancy Testing codes		
Z32.00	Encounter for pregnancy test result unknown	Use for pregnancy testing
Z32.01	Encounter for pregnancy test result positive	Use for pregnancy testing
Z32.02	Encounter for pregnancy test result negative	Use for pregnancy testing

Diagnosis Coding for PEP Related Services

The codes in this section apply to PEP visits and PEP lab services. This is a list of the most commonly used ICD-10 codes for the lab tests listed in this section. This list of codes was gathered from standard coding conventions and payer policy. Other payer policies may require additional or other ICD-10 to support payer-specific medical necessity requirements. A list of relevant diagnosis codes is at the end of this guide. Additionally, providers should reference the full ICD-10-CM Complete Official Codebook.

Not all the ICD-10 codes listed below should be used for every lab service. Because ICD-10 codes exist for each specific disease or disease category, codes for screening laboratory services are greater in number than those listed for visits. While there are general screening codes, there are also more specific codes for screening that are required by most payers for specific tests and conditions.

PEP ICD-10 – Initial and Subsequent Visits

Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.828	Contact with and exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
The following codes are included for completeness only. The codes above are typically sufficient. Avoid the use of the Z72.x codes that are considered stigmatizing because they indicate "problems related to lifestyle." However, some payers may require these codes for reimbursement.	
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior

PEP ICD-10 Codes Testing

ICD-10 Code	Description	Use For
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV	HIV screening
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.5	Contact with and (suspected) exposure to viral hepatitis	Hepatitis screening
Z20.828	Contact with and exposure to other viral communicable diseases	
Z20.89	Contact with and (suspected) exposure to other communicable diseases	
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease	
Z01.812	Encounter for preprocedural laboratory examination	Use for urine and blood test prior to initiation
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission	STI screening
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]	HIV screening

Z11.59	Encounter for screening for other viral diseases	
Z51.81	Encounter for therapeutic drug level monitoring	PEP monitoring
Z79.899	Other long term (current) drug therapy	PEP monitoring
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11 series indicated below.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.
The following codes are included for completeness only. The codes above are typically sufficient. Avoid the use of the Z72.x codes that are considered stigmatizing because they indicate "problems related to lifestyle." However, some payers may require these codes for reimbursement.		
Z72.51	High-risk heterosexual behavior	HIV, STI screening
Z72.52	High-risk homosexual behavior	HIV, STI screening
Z72.53	High-risk bisexual behavior	HIV, STI screening
Z72.89	Other problems related to lifestyle	Use for drug-seeking behavior or unhealthy drinking behavior
Opioid abuse --no specific code for IV use		
F11.10	Opioid abuse, uncomplicated	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.90	Opioid use, uncomplicated	
Pregnancy-Related ICD-10 codes		
Z32.00	Encounter for pregnancy test result unknown	
Z32.01	Encounter for pregnancy test result positive	
Z32.02	Encounter for pregnancy test result negative	

V.

PrEP Visits

Before receiving a PrEP prescription, an individual needs counseling and lab testing. In 2021, the CDC published updated clinical guidelines for PrEP.[25]

PrEP is preventive in nature. As such, both the CPT® code and the ICD-10 code must be preventive by definition. Initial conversations regarding PrEP initiation may occur in a variety of settings and during a variety of medical services. As a part of these counseling conversations, lab tests must be ordered by a physician, APRN, or PA. If the counseling is done by one of these professionals at initiation or in follow-up, use this PrEP visit Decision Tree to ensure all services provided during an encounter are reportable. PrEP counseling services at initiation and for follow-up counseling and adherence may be reported using the Preventive Medicine counseling codes.

CPT® describes services by type of service and at times by location of service. This guide addresses outpatient services only. Outpatient medical visits associated with PrEP may take place in the Emergency Department (ED). New or established patient ED services are represented by a specific code set: 99281-99285. All other outpatient visit services referenced in this guide refer to but are not limited to the following locations, which may be identifiable by a POS code:[26]

- Physician office
- Outpatient hospital
- Clinic
- Federally Qualified Health Center (FQHC)
- Rape crisis center
- Departments of health
- School clinic
- Mobile clinic
- Urgent care facility
- Campus clinic
- Community health center

Unless otherwise specified within this guide, all visit codes referenced must be performed by a licensed and enrolled practitioner. Licensing requirements vary from state to state. Enrollment and supervision requirements vary from payer to payer. Compliance with licensing, supervision, and enrollment requirements is the responsibility of the organization in which the service is performed.

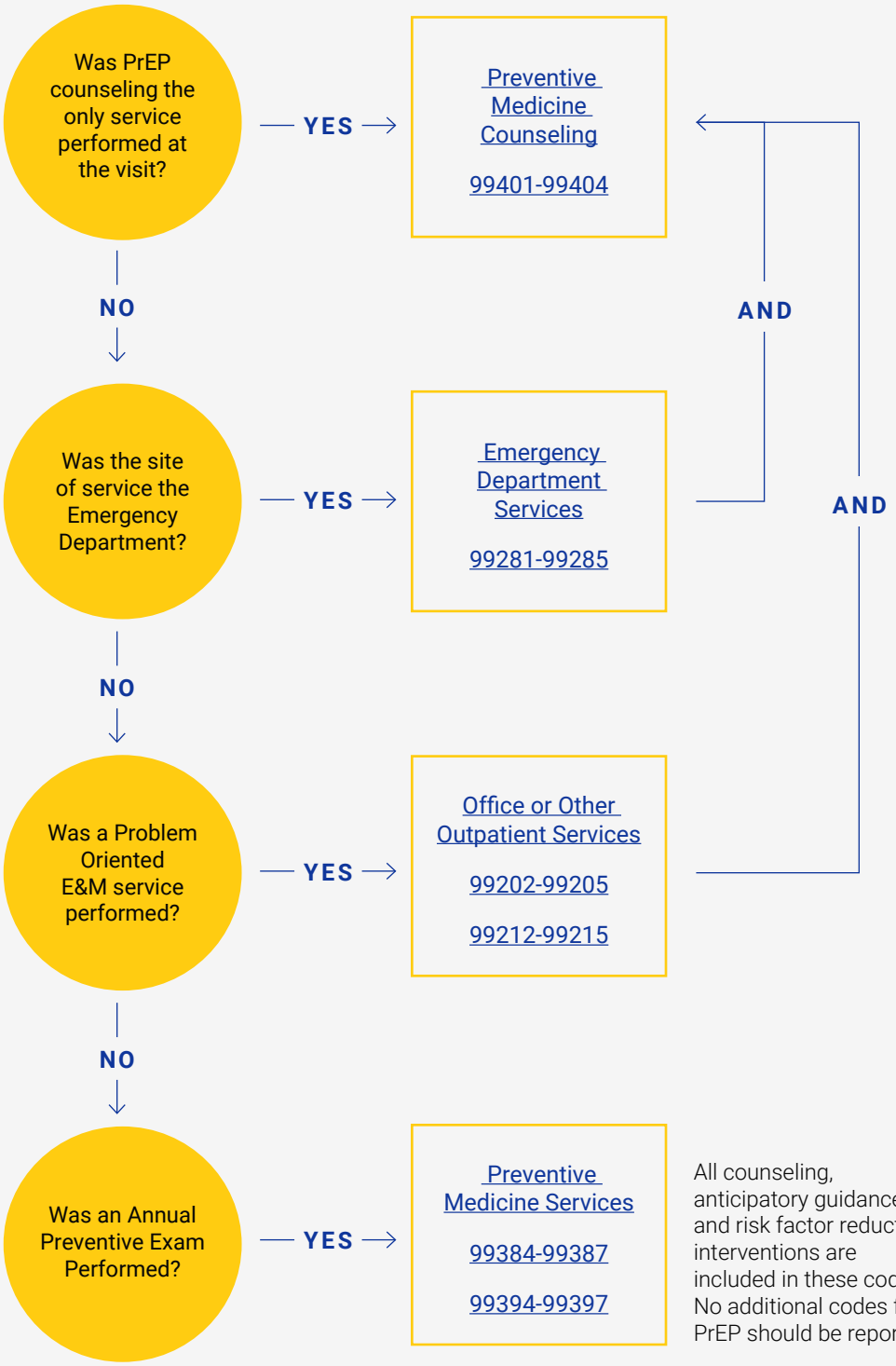
For FQHCs, the billing process is not altered for PrEP or PEP visits. PrEP and PEP visits are considered medical visits. The visit must meet the payer-specific requirements for a qualifying visit, including provider

[25]CDC Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 update can be accessed here https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

[26]CMS Place of Service Code Set https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

type, location, face-to face requirements, and CPT code. Medicare guidance for FQHC billing can be found in the Medicare Claims Processing Manual.[27] FQHC and Rual Health Clinic (RHC) billing regulations for Medicaid and Medicaid Managed Care Organizations (MCO) vary by state.

PrEP E&M Counseling Decision Tree



[27]Medicare Claims Processing Manual Chapter 9 - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

Preventive Medicine Counseling

Prior to receiving a prescription for PrEP, a healthcare professional has a discussion with the patient and orders lab testing. Based on the provider's description of services, CPT® definition, and payer policies, Preventive Medicine Counseling should be used to report PrEP counseling services at both initiation and subsequent visits. These preventive medicine codes are intended to be used in the absence of an established diagnosis, to promote health, prevent illness, and for risk factor reduction.

CPT® Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an **individual** (separate procedure); approximately 15 minutes
99402	approximately 30 minutes
99403	approximately 45 minutes
99404	approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a **group** setting (separate procedure); approximately 30 minutes
99412	approximately 60 minutes

How to report these codes:

- These codes are used to document preventive counseling in patients without a diagnosis. Counseling for PrEP adherence in patients without HIV fits into this description.
- As with all time-based codes, document the time of the face-to-face counseling in the medical record and describe the counseling. If these codes are reported with other time-based codes, documentation of the time for each service is required. No overlap of time is allowed when determining reportable codes.
- Link preventive ICD-10 codes to these preventive counseling codes.
- In the above description, *Separate Procedure*[28] means that these codes may be reported separately when performed at a visit that is not otherwise preventive in nature.
- Not all payers have adopted this code for PrEP visits. See payer-specific PrEP Guidance.
- These codes have a status indicator of non-covered for Medicare. See Medicare-specific codes. *[CPT codes that represent Preventive Counseling are not covered by traditional Medicare. At the time of publication (October 2023), CMS had not published a final NCD regarding PrEP. However, the CMS process for the publication of an NCD is at the NCA[29] phase of the process. It is expected to be finalized shortly. Supplemental materials will be shared.*

[28]AMA https://cpt-international.ama-assn.org/cpt-implementation-guide-component-2-primer
"Separate Procedure: Some of the procedures or services listed in the CPT® Professional Edition book that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure.".

[29]CMS National Coverage Analysis (NCA: Preexposure Prophylaxis (PrEP) Using Antiretroviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=310

- Payer Notes: Some payers may limit benefit coverage to only a subset of these codes. Refer to payer policy to determine CPT® code coverage. Indiana Medicaid (IHCP)[30] lists only 99401 as a payable code.

Emergency Department Services

Initial counseling for PrEP may occur in the emergency department of a hospital. Both emergency department (ED) and PrEP counseling service codes may be reported for the same encounter. No distinction is made between new and established patients. No time is associated with this code set. The determining factor in emergency department code choice is the level of medical decision-making, noted in bold below.

CPT® Code	Description
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision-making.
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **low** medical decision-making.
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** medical decision-making.
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high** medical decision-making.

How to report these codes:

- These ED Codes are problem-oriented codes. Report ICD-10 codes associated with the problem addressed during the emergency department visits.
- These ED service codes are not PrEP codes and as such are not subject to ACA cost-share protections.[31]
- If PrEP counseling was rendered and documented during the ED encounter, Preventive Medicine Counseling Codes may be reported in addition to these codes.
  - Document time and topics of the PrEP counseling separate from the ED services.
  - Choose the PrEP counseling code based on the time documented.
  - Append Modifier 25 to the Emergency Department CPT® codes (99282-99285). Payer-specific instruction may require Modifier 25 on the Preventive Medicine Counseling codes.

[30]The Indiana Health Coverage Programs (IHCP) publishes reimbursement information regarding all Common Procedural Terminology (CPT©), Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT©2) codes, as well as NUBC Official UB-04 Specifications, recognized by the IHCP through the following fee schedules.https://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp

[31]Kaiser Family Foundation: Preventive Services Covered by Private Health Plans under the Affordable Care Act https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/

Office/Outpatient Medical Visits

Initial counseling for PrEP may occur during a problem-oriented visit in a physician's office or other outpatient setting. Both office visits and PrEP counseling service codes may be reported for the same encounter.

New Patient	Time Range in minutes	Established Patient	Time Range in minutes
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54

How to report these codes:

- Choose codes based on the new versus established status of the patient and total time spent on the date of the encounter; excluding PrEP counseling time
- These are problem-oriented codes. Report ICD-10 codes associated with the problem addressed during the office visit.
- These office visit service codes are not PrEP codes and as such are not subject to ACA cost-share protections.
- If PrEP counseling was rendered and documented during the office encounter, Preventive Medicine Counseling Codes may be reported in addition to these codes.
  - Document the time and topics of the PrEP counseling separately from the documentation of time for the office visit services.
  - Choose the PrEP counseling code based on the time documented for PrEP counseling only.
  - Append Modifier 25 to the office CPT® codes (99202-99255). Payer-specific instruction may require Modifier 25 on the Preventive Medicine Counseling codes.
- Although not common,[32] payer guidance may recommend these codes for PrEP initiation and follow-up visits. Patient cost-share protections will be difficult to enforce with this type of service reporting. Verify payer guidance. If confirmed by the payer, it is recommended to append Modifier 33: USPSTF Covered Preventive Service and link the service to ICD-10 Z29.81 - Encounter for HIV pre-exposure prophylaxis.

[32]United Health Care recommends the use of the codes for PrEP visits and also allows them for Telehealth https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/preventive-care-services.pdf https://www.uhcprovider.com/content/dam/provider/docs/public/policies/attachments/reimbursement/Telehealth-Eligible-Services-Code-List.pdf

Preventive Medicine Visits

Initial counseling for PrEP may occur during an annual physical in a physician's office or other outpatient setting. These codes are organized by new versus established patient status of the patient and then by patient age.

New Patient	Age Range	Description
99384	12-17	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures
99385	18-39	
99386	40-64	
99387	65 and older	
Established Patient	**Age Range**	**Description**
99394	12-17	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender-appropriate history, examination, counseling / anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures
99395	18-39	
99396	40-64	
99397	65 and older	

How to report these codes:

- These codes are to report annual preventive physicals.
- As preventive services, these visits are covered under the ACA with cost-share protection for the patient.
- These codes include *"counseling /anticipatory guidance/risk factor reduction interventions"*. Additional PrEP counseling cannot be billed in addition to these codes.
- These codes may have benefits limitations under patient plans. That is, a plan may limit these to one or two per benefit year. Typically, a patient's Primary Care Provider is most likely to use these codes.
- ****Traditional Medicare does not cover these codes.[33] See Medicare-specific code section in this guide*****

[33]Medicare Advantage or Medicare Part C Plans may cover these annual physical codes.

VI.

TelePrEP

What is TelePrEP and how does it differ from in-person PrEP visits?

TelePrEP visits are telehealth visits specifically for PrEP. Telehealth refers to the use of telephone or video visits between a clinician and a patient in lieu of in-person visits. There are many programs that will provide PrEP-related professional services, laboratory services, and medications free of charge to the patient. The TelePrEP section of this guide will focus on best practices for billing, coding, and reimbursement of TelePrEP services. Telehealth benefits were expanded during the COVID-19 Federal Public Health Emergency.[34] There have been extensions to this more expansive coverage, but it is best to verify the status of payer-specific telehealth services on a regular basis.

The services rendered by a telePrEP provider or program are the same as those administered when the services are face-to-face. State Medicaid Programs and private payers have very specific reporting guidelines for telehealth. These telehealth guidelines do not always reconcile well with the same payer's PrEP guidelines. Not all CPT codes are accepted by all payers as telehealth services. The obstacles to payment described previously for PrEP also exist for telePrEP. However, the additional elements must be considered and verified with payers to reduce the likelihood of denial. As with billing and reimbursement for in-person visits, the risk of denial or misprocessing of claims can be mitigated by identifying and following the PrEP and Telemedicine payer policies for the highest volume payers for your organization.

The two elements that are specific to telehealth services are Technology modifiers and POS codes.

Telehealth or Technology Modifiers

Append appropriate modifiers to all services provided via a telecommunication system.

Modifier	Description	Note
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	This is the most commonly accepted Telehealth technology modifier.
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	Audio only. Verify that payer policy covers audio-only telehealth.
FQ	The service was furnished using audio-only communication technology	Audio only. Verify that payer policy covers audio-only telehealth.
GT	Via interactive audio and video telecommunication systems	Although not expired, this modifier has been replaced by Modifier 95. GT is a very infrequently used modifier. It is included in this guide for completeness.

[34]The Consolidated Appropriations Act of 2023 (PDF) authorized the extension of many of the telehealth flexibilities through December 31, 2024. https://telehealth.hhs.gov/providers/telehealth-policy/medicare-and-medicaid-policies

Place of Service Codes

POS codes are two-digit codes reported on claims to identify the setting in which the service was provided. The POS code is not selected by the provider but systematically identified by the clinic or practice location for which the appointment was created.

Telehealth POS codes

02 – Telehealth provided other than in patient home

The location where health services are provided or received through telecommunications. The patient is physically not located in their home when receiving these related health services via telecommunication technology.

10 – Telehealth provided in patient home (effective January 1, 2022)

The location where health services are provided or received through telecommunications. The patient is physically in their home (a location other than a hospital or facility where the patient receives care in a private residence) when receiving these related health services via telecommunication technology.

TelePrEP Visits

Preventive Medicine Counseling

These codes most accurately reflect the preventive service performed during a PrEP initiation or follow-up visit. If these codes are allowed by the payer as a telehealth service, report them. All documentation and reporting requirements as described in the PrEP Visit section still apply.

CPT® Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an **individual** (separate procedure), approximately 15 minutes
99402	approximately 30 minutes
99403	approximately 45 minutes
99404	approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a **group** setting (separate procedure); approximately 30 minutes
99412	approximately 60 minutes

Office/Outpatient Medical Visits for TelePrEP Services

Although not common,[35] payer guidance may require these codes for PrEP initiation and follow-up visits. Therefore, these codes would also be reported for telePrEP visits if the Preventive Medicine Counseling codes are not accepted by the payer.

Patient cost-share protections may be difficult to enforce with this type of service reporting. Verify payer guidance. If confirmed by the payer, it is recommended to append Modifier 33: USPSTF Covered Preventive Service in addition to the technology modifier.

New Patient	Time Range in minutes	Established Patient	Time Range in minutes
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54

Online Digital Assessment and Management or Evaluation and Management Services

Patient cost-share protections will be difficult to enforce with this type of service reporting. Verify payer guidance. If confirmed by the payer, it is recommended to append Modifier 33: USPSTF Covered Preventive Service in addition to the technology modifier.

Qualified **non physician healthcare professional** online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days;		
98970	5-10 minute	These are weekly (7 days) cumulative totals. Document each tele-visit and bill weekly based on the total time.
98971	11-20 minutes	
98972	21 or more minutes	
99205	60-74	

The online and telephone Evaluation and Management codes below may be reported by physicians or other qualified healthcare professionals.

Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;		
99421	5-10 minutes	These are weekly (7 days) cumulative totals. Document each tele-visit and bill weekly based on the total time.
99422	11-20 minutes	
99423	21 or more minutes	

Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment;		
99441	5-10 minutes of medical discussion	
99442	11-20 minutes of medical discussion	
99443	21-30 minutes of medical discussion	
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion	

TelePrEP Laboratory Services

Laboratory services for telePrEP encounters are ordered by the provider rendering the telePrEP visit. The timing and frequency of the CDC-recommended monitoring should be maintained. These lab services may be performed using self-collection test kits when appropriate. Alternatively, there may be visits for specimen collection only. The choice may be client preference, provider preference, or a cost-based decision.

See the Lab Services section of this guide for full information.

Medication

Oral PrEP can be prescribed and mailed directly to the patient's home or picked up at the pharmacy of the patient's choice. Long acting or injectable PrEP is prescribed less frequently in a telehealth environment because it requires in-person encounters for provider injection.

VII.

Labs for PrEP Initiation and Supplemental Testing

The USPSTF granted PrEP an A grade, recommending that healthcare providers offer PrEP to individuals at high risk for HIV acquisition. This recommendation includes lab testing for HIV, STIs, lipids, hepatitis B, and hepatitis C. The medical provider may also order a metabolic panel and/or pregnancy test. The CDC PrEP Clinical Practice Guidelines includes more specificity on the recommended frequency of PrEP-related laboratory testing; these guidelines are referenced in the USPSTF recommendation. Payers use the CDC guidelines to set their own guidance for how and when these tests will be paid. After starting PrEP medication, the medical provider will order lab tests at the prescribed intervals. If the interval at which the labs are ordered and performed is shorter than what the payer has included in its guidance, even by one day, the lab may be denied for frequency violation. The intervals allowed for the lab services are benefits that are associated with the patient, not the provider. If another provider has ordered or performed this lab test within the prescribed time, additional services may be denied.

Although screening for HIV, syphilis, gonorrhea, chlamydia, and hepatitis B and C are assigned grades A and B by the USPSTF outside of PrEP, the frequency allowed under the PrEP recommendation is more frequent than the previous screening recommendations. In order to secure payment and zero cost share for the patient, it is critical to indicate that the service ordered is a part of PrEP initiation and continuation. There are two ways to accomplish this.

- Indicate ICD-10 Code Z29.81 - Encounter for HIV pre-exposure prophylaxis
- Append Modifier 33 – USPSTF Grade A or B to any non-screening lab codes.
-

Some payers do not accept Modifier 33. The modifier may be removed from the claim, but follow-up will be required to ensure that the claim is processed with an accurate cost-share application.

Modifiers for use when reporting laboratory services:

Modifier	Description
33	**Preventive Services:** When the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating. For separately reported services specifically identified as preventive, the modifier should not be used
92	**Alternative Laboratory Platform Testing:** When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber
59	**Distinct Procedural Service** indicates that a procedure is separate and distinct from another procedure on the same date of service. For lab services that may mean the same test on different specimens.
QW	Clinical Laboratory Improvement Amendment (CLIA) waived test[36]

The laboratory CPT® codes included in this section of the guide are a comprehensive list for each infectious agent for which a specimen is being tested. Payer medical policy may require the use of certain codes to provide benefits. For example, although fourteen CPT® codes for HIV testing are included, Blue Cross Blue Shield of North Carolina provides coverage for only 87806 according to their PrEP coverage guidelines.[37] Some G codes, temporary codes issued by CMS, have been included in this list as commercial payers are permitted to adopt these codes. **The codes in bold for each category are the more commonly used codes for PrEP initiation and monitoring**. However, the decision regarding tests ordered remains with the clinician.

Table 5: Timing of Oral PrEP-associated Laboratory Tests and Table 7: Timing of CAB PrEP-associated Laboratory Tests can be found in CDC's Clinical Practice Guidelines. These tables are also referenced in the PrEP Drugs and Administration section of this guide.

HIV

CPT® Code	Description
87806	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation, HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
86689	HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	Antibody. HIV-1
86702	Antibody. HIV-2
86703	Antibody. HIV-1 and HIV-2, single result
	(For HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result, use 87389)
87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics
87903	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; first through 10 drugs tested
87904	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested (List separately in addition to code for primary procedure)
	(When HIV immunoassay [HIV testing 86701-86703 or 87389] is performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual code)
Infectious agent detection by nucleic acid (DNA or RNA);	
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed

[36]CLIA Waived Tests require Modifier QW. CMS typically publishes new waived test transmittals four times per year. The latest list published in June 2023 effective 10/2/2023 can be found here https://www.cms.gov/files/document/r12089cp.pdf

[37]See page 8 of BlueCross BlueShield of North Carolina's Health Care Reform Preventive Services Coding Guide. https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/bcbsnc_hcr_preventive_services.pdf

87536	HIV-1, quantification, includes reverse transcription when performed
87357	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique, includes reverse transcription when performed
87539	HIV-2, quantification, includes reverse transcription when performed
Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method	
87389	**HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result**
87390	HIV-1
87391	HIV-2
For Medicare patients	
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique
G0435	Infectious agent antibody detection by rapid antibody test.
G0475	HIV antigen/antibody, combination assay, screening

Creatinine Clearance

CPT® Code	Description
82575	Creatinine; clearance
82565	Creatinine; blood
82570	Creatinine; other source

STI screening

Screening for syphilis

CPT® Code	Description
86592	Syphilis test, non-treponemal antibody, qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody, quantitative
86780	Treponema pallidum

Screening for gonorrhea

CPT® Code	Description
87590	Neisseria gonorrhoeae, direct probe technique
87591	**Neisseria gonorrhoeae, amplified probe technique**
87592	Neisseria gonorrhoeae, quantification
87850	Infectious agent antigen detection by immunoassay with direct optical observation, Neisseria gonorrhoeae

Screening for chlamydia

CPT® Code	Description
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 immunofluorescent technique chlamydia trachomatis
87490	Chlamydia trachomatis, direct probe technique
87491	**Chlamydia trachomatis, amplified probe technique**
87810	Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis

Lipid Panel

CPT® Code	Description
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)

Hepatitis screening

Screening for Hepatitis B

CPT® Code	Description
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
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;	
87340	**Hepatitis B surface antigen (HBsAg)**
87341	Hepatitis B surface antigen (HBsAg) neutralization
87467	Hepatitis B surface antigen (HBsAg), quantitative

Screening for hepatitis C

CPT® Code	Description
86803	**Hepatitis C antibody**
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot)
G0472	Hepatitis C antibody screening, for individuals at high risk and other covered indication(s)

Pregnancy Testing

CPT® Code	Description
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG), quantitative
84703	Gonadotropin, chorionic (hCG), qualitative

Obstetric Panels Descriptions below are exact CPT® language. See official AMA or CPT® resources for clarification	
80081	Obstetric panel (includes HIV testing): This panel must include the following: • Blood count, complete (CBC), and automated differential white blood count (85025 or 85027 and 85004) OR • Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) • Hepatitis B surface antigen (HBsAg) (87340) • HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) • Antibody, rubella (86762) • Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) • Antibody screen, RBC, each serum technique (86850) • Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)
80055	Obstetric panel: This panel must include the following: • Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR • Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) • Hepatitis B surface antigen (HBsAg) (87340) • Antibody, rubella (86762) • Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) • Antibody screen, RBC, each serum technique (86850) • Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)

Self-Testing[38]

Self-Testing refers to the method of testing where the consumer collects the specimen, performs the test, and interprets the results. This method is performed in the home or other non-healthcare setting.

These test kits are not typically covered by any health insurance benefit. The consumer typically purchases these tests from a retail source or may receive them from a health department for free. The results of these tests may prompt contact with a health professional for medical advice. This may occur in person or by phone.

Self-Collection and Laboratory Testing

A self-collection kit includes the necessary devices for a patient to collect specimens for testing in the convenience of their own home or location of their choosing. Self-collect kits can be ordered from an online telehealth provider, in-office provider, commercial testing service, or some may be purchased at a pharmacy or store.

[38]For additional information about self-testing see ***NASTAD's Self-Testing: A Strategy to Improve Access to HIV, Vial Hepatitis and STI Testing*** here https://nastad.org/sites/default/files/2021-11/PDF-Self-Testing-Toolkit.pdf

The consumer follows the laboratory instructions for specimen collection, then packages the specimens as directed and sends the sample/s to the laboratory for testing.
The laboratory or provider service may charge a fee for kitting and fulfillment.

The laboratory will bill for testing ordered and performed.

Per the CDC, for chlamydia and gonorrhea, patient self-collected samples have equivalent performance as clinician-obtained samples and can help streamline patient visit flow.[39]

On May 15, 2020, the CDC published a Dear Colleague letter[40] regarding PrEP during COVID or when in-person lab-only visits are not available or feasible. It states, in part:

Quarterly HIV testing should be continued for patient safety. Lab-only visits for assessment of HIV infection and other indicated tests for the provision of PrEP are preferred. When these are not available or feasible, CDC recommends considering two additional options.

- The first option is a home specimen collection kit for HIV and sexually transmitted infection (STI) tests, which is covered by most insurance plans and can be ordered by clinicians. Some laboratories have validated protocols for testing home-collected samples for the panel of tests required for those initiating or continuing PrEP. Specimen kits are mailed to the patient's home and contain supplies to collect blood from a fingerstick or other appropriate method (e.g., self-collected swabs and urine). The kit is then mailed back to the lab with test results returned to the clinician who acts on results accordingly. This laboratory-conducted test is sensitive enough to detect recent HIV infection.
- The second option is self-testing via an oral swab-based test. Although this type of HIV self-test is usually not recommended for PrEP patients due to its lower sensitivity in detecting recent HIV infection during PrEP use, clinicians could consider use of these tests when other options are not available.

[39]Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 UPDATE page 32 https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

[40]HIV self-testing allows people to take an HIV test and find out their result in their own home or other private location. The availability of HIV self-tests in the US may help increase awareness of HIV infection for people who wouldn't otherwise get an HIV test. While HIV self-tests are available for retail purchase by consumers, CDC encourages health departments to consider HIV self-testing as an additional testing strategy to reach persons most affected by HIV. Findings from self-testing research and additional resources provided below may be helpful if you are considering offering HIV self-testing in your program. CDC Home Specimen Collection Kit https://www.cdc.gov/hiv/testing/self-testing.html

VIII.

PrEP Drugs and Administration

The FDA has approved three drugs for PrEP for the prevention of HIV infection. As a result of the USPSTF A grade recommendation for PrEP, under the ACA, PrEP-related services and medications are not subject to deductibles, co-insurance, or co-pays. That means that all non-grandfathered health insurance plans and Medicaid expansion benefits must cover PrEP medication without cost sharing. However, payers are permitted at their discretion to define the requirements for coverage.[41] It is critical that the provider, retail pharmacy, or specialty pharmacy is aware of coverage requirements and limitations. Some of the more common obstacles to coverage are:

- Prior Authorization: Plans may require certain criteria to be met and documented by a provider before a particular medication will be covered
- Step Therapy: For more expensive medications, some plans require an attempt at a less expensive but proven treatment first
- Medical vs Pharmacy Benefit
  - Medication dispensed in an outpatient setting via pharmacies (typically self-administered) is more likely to be covered under a prescription drug benefit.
  - Medication typically administered by a healthcare professional, i.e., an injection may be more likely to be covered under the medical benefit

Each patient's clinical situation is different. In addition, each plan may have different requirements for coverage. These variables are cumbersome and time-consuming for both patients and providers, but are part of our health insurance and necessary to understand and navigate.

Two of the approved medications for PrEP are oral and the third is injectable. Each category has its own CDC recommendations for the timing of laboratory testing. Two examples of coverage requirements.

Table 5 - *Timing of Oral PrEP-associated Laboratory Tests* and Table 7- *Timing of CAB PrEP-associated Laboratory Tests* from the CDC PrEP Clinical Practice Guidelines are included here for reference. The screening intervals for PrEP may vary from published payer medical policy guidelines. However, all non-grandfathered plans must comply with USPSTF Grade A PrEP recommendations.

[41]United Healthcare and CIGNA have published Drug and Biologic Coverage Policies for reference. UnitedHealthcare Pharmacy Oxford Plans only https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/drugs-pharmacy/commercial/a-g/PA-Med-Nec-Descovy.pdf Cigna Drug and Biologic Coverage Policy HIV Products for Individual and Family Plans https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0090_coveragepositioncriteria_hiv_products_ifp.pdf

Oral PrEP

Oral PrEP uses antiretroviral drugs in pill form to virtually eliminate the risk of HIV infection when taken regularly. There are two forms of approved oral PrEP:

- Tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC) (TDF/FTC or brand name Truvada®)
- Tenofovir alafenamide fumarate (TAF), and emtricitabine (FTC) (TAF/FTC or brand name Descovy®)

Both are prescribed as daily pills. TDF/FTC is available in generic form, but TAF/FTC is only available as a brand-name drug.

Self-administered drugs are medications that can be used on an outpatient basis and that do not typically require clinical supervision or assistance to consume, apply, or inject. With limited exceptions, routes of administration, including but not limited to oral and topical, are frequently designated as self-administered medications. Most self-administered drugs are covered under a patient's pharmacy benefit. Therefore, oral PrEP medications are ordered by a licensed prescriber and billed by a retail or specialty pharmacy identifying the product dispensed through National Drug Codes (NDCs). These unique ten- or eleven-digit numbers are universal product identifiers that are present on all non-prescription and prescription medication packages.

In 2019, the USPSTF issued a graded recommendation to prescribe oral PrEP to adult patients who are at risk of getting HIV through sex (grade A).

The following table from the CDC PrEP Clinical Practice Guidelines indicates the baseline and ongoing assessments required for patients on oral PrEP.

Table 5 Timing of Oral PrEP-associated Laboratory Tests[42]

Test	Screening Baseline Visit	Every 3 months	Every 6 months	Every 12 months	When stopping PrEP
HIV	X	X			X
Creatinine Clearance Test	X		If age ≥50 or eCrCL <90 ml/min at PrEP initiation	If age <50 and eCrCl ≥90 ml/min at PrEP initiation	X
Syphilis	X	MSM /TGW	X		MSM/TGW
Gonorrhea	X	MSM /TGW	X		MSM/TGW
Chlamydia	X	MSM /TGW	X		MSM/TGW
Lipid Panel (F/TAF)	X			X	
Hep B Serology	X				
Hep C serology	MSM, TGW, and PWID only			MSM, TGW, and PWID only	

[42]Table 5, page 44 of CDC PrEP Clinical Practice Guidelines https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

Injectable PrEP

The FDA has approved one injectable PrEP medication: cabotegravir (CAB) 600 mg (Apretude®). This medication is only available as a brand-name drug. CAB is a single antiretroviral drug given as an intramuscular injection every two months to prevent HIV. In 2023, the USPSTF issued a graded recommendation to prescribe CAB for PrEP.[43] Unlike oral PrEP medications, injectable or long-acting PrEP (CAB) may be covered under a patient's medical or pharmacy benefit. If covered under the medical benefit and all coverage requirements are met, then the provider may bill for this medication and its administration on the professional claim. Obtaining these and billing for these specialty injectable drugs will require researching options and developing a process that works best for the provider organization.[44] If obtaining the drug for administration at the provider site is impractical, explore alternative sites of administration as an option.[45] The patient and the provider may determine that an optional 30-day oral PrEP is beneficial. Please refer to the oral PrEP sections of this guide for billing and coding information.

In 2022, **HCPCS code J0739 - Injection, cabotegravir, 1 mg** was issued.

For each injection, encounter the provider administering the Cabotegravir will bill:

- 96372 -Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)
- J0739 - Injection, cabotegravir, 1 mg – One unit for every 1 mg injected
- Link ICD-10 code Z29.81 - Encounter for HIV pre-exposure prophylaxis should be linked to both the injection and the administration.
- If a documented and separately identifiable visit is reported on the same day as the 96372 injection administration code, append modifier 25 to the visit code.

Table 7 Timing of CAB PrEP-associated Laboratory Tests[46]

Test	Initiation Visit	1 month Visit	Every 2 months	Every 4 months	Every 6 months	Every 12 month	When Stopping CAB
HIV-1 RNA Assay	X	X	X	X	X	X	X
Syphilis	X			MSM/TGW only	Heterosexually active women and men only	X	MSM/TGW only
Gonorrhea	X			MSM/TGW only	Heterosexually active women and men only	X	MSM/TGW only
Chlamydia	X			MSM/TGW only	MSM/TGW only	Heterosexually active women and men only	MSM/TGW only

[44]Viiv: Video Library: Access and Acquisition https://cabenuvahcp.com/resources/all-resources/#

[45]ViiV Connect Alternative Site for Administration (ASA) Locator https://www.viivconnect.com/for-providers/injection-site-finder/#

[46]Table 7 page 50 of CDC PrEP Clinical Practice Guidelines https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

IX.

Medicare Specific Codes

As discussed in the Obstacles to Payment section of this guide, CMS issues and maintains HCPCS codes. From a billing perspective, G codes are typically temporary codes that describe professional services that do not have an assigned CPT® code yet. G codes are initially created for Medicare use. However, other payers are permitted to adopt these codes to represent services covered within their medical policies.

With legislation over the last three decades, Medicare has shifted from covering very few preventive services, to covering many preventive services that are evidenced-based and recommended by the USFTP. In order for CMS to add these services to Medicare coverage, Medicare has developed NCDs to specify circumstances for coverage for a specific medical service covered by Medicare Part B. NCDs are Medicare's medical policy publications. However, unlike other payers, Medicare can create, issue, and publish HCPCS codes for a specific benefit.

The AMA published CPT® Preventive Medicine Services codes in 1994; CPT® Codes 99381-99397. These CPT® codes represent age and gender-appropriate history, exam, counseling, risk factor reduction, and interventions. Based on clinical data, CMS determined that these CPT® codes did not accurately reflect the services their preventive benefit category would cover.

A Comprehensive Guide to Medicare Preventive Services can be found on the CMS' Medicare Learning Network[47]

At the time of publication (October 2023), CMS had not published a final NCD regarding Preexposure Prophylaxis (PrEP). However, the CMS process for the publication of an NCD is at the NCA phase of the process. It is expected to be finalized shortly. Supplemental materials will be shared.

Initial Preventive Physical Exam (IPPE)

Traditional Medicare[48] does not cover CPT® codes 99381-99397, Preventive Medicine Services. CMS has created HCPCS G codes to represent the annual wellness visits (AWV) covered for Part B beneficiaries.

IPPE is an introduction to Medicare for a beneficiary who has started his/her/their Medicare coverage. It is more commonly known as the "Welcome to Medicare" visit. It is not a "routine physical" that some beneficiaries may want to have yearly. If the beneficiary requests a "routine physical", it will not be covered by Medicare and the beneficiary will be liable for any balance. It gives a beneficiary an understanding of the Medicare-covered preventive services available.

G0402 — Initial preventive physical examination: face-to-face visit, services limited to new beneficiaries during the first 12 months of Medicare enrollment

[47]MLN Educational Tool Medicare Preventive Services – Select a service for Medicare NCD publications https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html

[48]Medicare Advantage or Medicare Part C Plans may cover these annual physical codes.

IPPE must include the following components

1. Review of individual's medical and social history with attention to modifiable risk factors for disease detection
   - Medical/surgical/family history
   - Diet
   - Current medications and supplements
   - History of alcohol, tobacco, and illicit drug use
   - Physical activities
2. Review of potential risk factors for depression or other mood disorders
   - Using any appropriate screening instrument recognized by national professional medical organizations to obtain current or past experience with depression or other mood disorders
3. Review of functional ability and level of safety
   - Hearing impairment
   - Activities of daily living
   - Fall risk
   - Home safety
4. Examination to include:
   - Height, weight, body mass index, blood pressure, visual acuity screen, and other factors as deemed appropriate based on the beneficiary's medical and social history
5. End-of-life planning, upon agreement of the individual
   - May either verbally discuss with the beneficiary or give written information about their ability to prepare an advance directive in the event that an injury or illness would cause him/her/them to be unable to make health care decisions and whether or not the provider is willing to follow the beneficiary's wishes
6. Education, counseling, and referral, as appropriate, based on results of review and evaluation services
7. Education, counseling, and referral including a brief written plan provided to the individual for obtaining appropriate screening and other preventive services
8. If PrEP counseling was rendered and documented during the office encounter, PrEP counseling services may be reported in addition to these codes.
   - Document the time and topics of the PrEP counseling separately from the documentation of time for the IPPE service.
   - Choose the PrEP counseling code based on the time documented for PrEP counseling only. Traditional Medicare does not cover the Preventive Medicine Codes; report counseling based on time with the patient using the Office E&M codes 99202-99215
   - Append Modifier 25 to the office CPT® codes (99202-99215). Payer-specific instruction may require Modifier 25 on the Preventive Medicine Counseling codes.
   - Link ICD-10 code for general adult medical exam Z00.00 or Z00.01 to the IPPE and link Z29.81 to the E&M code used to report PrEP counseling.
   - The publication of CMS NCD for PrEP will change the above guidance. At the time of publication (October 2023), CMS had not published a final NCD regarding PrEP. However, the CMS process for the publication of an NCD is at the NCA phase of the process. It is expected to be finalized shortly. Supplemental materials will be shared.

Annual Wellness Exams

AWV is designed to develop and update the prevention plan tailored to the patient on an ongoing basis. Like the IPPE, it is not a "routine physical checkup" and takes place after a patient has his/her/their first IPPE.

The AWV may be provided by physicians, nurse practitioners, PAs, and certified clinical nurse specialists. Medical professionals, including registered nurses, health educators, pharmacists, registered dietitians, nutritional professionals, other licensed practitioners, or a team of such medical professionals, working under the direct supervision of a physician, may also provide the AWV, if their state licensure allows them to do all components of the service.

G0438 — Annual wellness visit includes a personalized prevention plan of service (PPS), initial visit

The Initial AWV must include the following components[49]

- Health risk assessment
- Establishment of:
  - Individual's medical/family history
  - Current providers and suppliers
- Measurement of his/her/their height, weight, body-mass index (BMI) or waist circumference and blood pressure
- Detection of any cognitive impairment
- Review of individual's risk factors for depression, including current or past experiences with depression or other mood disorders
- Review of individual's functional ability and level of safety based on direct observation or the use of appropriate screening questions or screening questionnaire
- Establishment of:
  - Written screening schedule for individual, such as a checklist for the next five – 10 years, based on USPSTF and Advisory Committee on Immunization Practices (ACIP) recommendations, the individual's health risk assessment, health status, screening history, and age-appropriate preventive services covered by Medicare
  - List of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or risk factors
- Furnishing of personalized health advice and referral, if appropriate, to health education or preventive counseling services aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

G0439 — Annual wellness visit, includes a personalized PPS, subsequent visit

The subsequent Annual Wellness Visits must include the following components

- Review, and administration if needed, of updated health risk assessment
- Update of individual's medical/family history
- Update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual

[49]CMS Medicare Learning Network – Medicare Wellness Visits https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

- Measurement of individual's weight or waist circumference, blood pressure and other routine measurements as deemed appropriate based on individual's medical/family history
- Detection of any cognitive impairment that the individual may have
- Update the following:
  - Written screening schedule for individual that was developed at the initial AWV
  - List of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual
- Furnishing of personalized health advice to individual and referral, as appropriate, to health education or preventive counseling services or programs

As indicated on the Visits Decision Tree medically necessary E&M services can be billed for at the same visit as the IPPE or AWV when clinically appropriate. Modifier 25 must be added to the E&M to show it is a significant, separately identifiable service from the IPPE.

If PrEP counseling was rendered and documented during the office encounter, PrEP counseling services may be reported in addition to these codes.

- Document the time and topics of the PrEP counseling separately from the documentation of time for the AWV service.
- Choose the PrEP counseling code based on the time documented for PrEP counseling only. Traditional Medicare does not cover the Preventive Medicine Counseling Codes; report counseling based on PrEP counseling time using the Office Evaluation & Management codes 99202-99215
- Append Modifier 25 to the office CPT® codes (99202-99215). Payer-specific instruction may require Modifier 25 on the Preventive Medicine Counseling codes.
- Link ICD-10 code for general adult medical exam Z00.00 or Z00.01 to the AWV and link Z29.81 to the E&M code used to report PrEP counseling.
- The publication of CMS NCD for PrEP will change the above guidance. At the time of publication (October 2023), CMS had not published a final NCD regarding PrEP. However, the CMS process for the publication of an NCD is at the NCA phase of the process. It is expected to be finalized shortly. Supplemental materials will be shared.

High-Intensity Behavioral Counseling to prevent STIs.

The USPSTF recommends high-intensity behavioral counseling (HIBC) for all sexually active adolescents and for adults who are at increased risk for STIs. This service was granted a B grade. As such, this service is subject to ACA preventive services coverage and cost-share protections. In addition to the lab tests screening for STIs, the USPSTF recommends semi-annual counseling. In response to this recommendation, Medicare created the following code. As discussed in the Obstacles to Payment section of this guide, non-Medicare payers are permitted to adopt the temporary G codes. This code is referenced again in the Other Counseling Services section of this guide.

> **G0445** – HIBC to prevent STI: face-to-face, individual, and includes education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes

Per Medicare, HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance, which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements.

Physicians, APRNs and PAs may provide the service in a primary care setting. Private payer policies may allow these counseling services to be performed by a staff member under the supervision of a physician, APRN, or PA. However, Medicare and most Medicaid plans only allow payment for these services when personally performed by a physician AP, or PA. Always confirm payer guidelines before providing the service.

How to use this code:

- Use this code for individual face-to-face counseling, which includes education skills training and guidance on how to change sexual behavior.
- The service can be provided to individuals with multiple sex partners, those who are using barrier protection inconsistently, those who were having sex under the influence of alcohol or drugs, those who were having sex in exchange for money or drugs, those who are aged 24 years or younger and sexually active for women with chlamydia and gonorrhea, those who have had an STI within the past year, persons who inject drugs (hepatitis B only), and men who are having sex with men.
- Medicare has specific restrictions regarding the provider and the setting. However, most other payers include this service in their Preventive Care Services Coverage Policy without restriction to provider and place.
- For Medicare, the service must be provided by a Medicare-eligible primary care provider in a primary care setting. See Medicare NCD below.
- These codes could be used for HIV negative or positive individuals.

G0445 may have been adopted by commercial payers and some Medicaid programs.

Laboratory Screening Codes

CMS has issued HCPCS G codes to clearly differentiate laboratory services that are used for screening when a CPT® code does not exist that specifies screening. These Medicare G codes are also included in the Lab Services section of this guide.

HCPCS	Description	Medicare Note
G0499	Hepatitis B screening in non-pregnant, persons at high risk- includes hepatitis B surface antigen (HBsAg), antibodies to HBsAg (anti-HBs) and antibodies to hepatitis b core antigen (anti-HBc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive HBsAG result	Medicare code for Asymptomatic, Non-Pregnant Adolescents and Adults at high risk See NCD here
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	See NCD here
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique	See HIV Screening NCD here
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique	
G0435	Infectious agent antibody detection by rapid antibody test.	
G0475	HIV antigen/antibody, combination assay, screening	

CMS NCD 210.7 indicates the following ICD-10 requirements with HIV screening. Report codes as applicable to the patient.

1. Increased risk factors not reported: Z11.4
2. Increased risk factors reported: Z11.4 and Z72.51, Z72.52, Z72.53, or Z72.89
3. Pregnant patients: Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93

X.

Other Counseling Services

Adherence counseling performed by a physician, APRN, or PA in an outpatient setting may be billed with the same codes as listed in PrEP visits, at the start of this guide, new and established patient E&M services (99201—99215) and preventive medicine counseling (99401—99412). With appropriate documentation, a physician, APRN, or PA could provide time-based counseling for a patient using office visit codes or preventive medicine counseling codes. See the section on PrEP initiation for a discussion of these services.

In addition, there are codes for very specific situations that may be applicable in the event that the previously discussed codes do not seem suitable or are insufficient for the service provided. These codes may be used for adherence, and other counseling services.

High-intensity behavioral counseling to prevent STIs

This service code was originated by Medicare as discussed in the Medicare Specific Codes section of this guide. It has been included here to highlight the fact that this code has been adopted by many commercial payers[50] and plans as a payable service in addition to the Preventive Medicine Counseling codes.

The USPSTF recommends HIBC for all sexually active adolescents and for adults who are at increased risk for STIs. This service was granted a B grade. As such, this service is subject to ACA preventive services coverage and cost-share protections. In addition to the lab tests screening for STIs, the USPSTF recommends semi-annual counseling.

For PrEP, this service could be utilized to extend counseling benefits when other screening counseling benefits have been or will be exhausted in a benefit year. This service would include counseling for sexual risk reduction or risk avoidance. The topics can be very flexible and adaptable to the patient's situation.

> **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

Physicians, advanced practice nurses, and physician assistants may provide the service in a primary care setting. Private payer policies may allow these counseling services to be performed by a staff member under the supervision of a physician, APRN, or PA. However, Medicare and most Medicaid plans do not However, Medicare and most Medicaid plans only allow payment for these services when personally performed by a physician AP, or PA. Always confirm payer guidelines before providing the service.

How to use this code:

- Use this code for individual face-to-face counseling, which includes education skills training and guidance on how to change sexual behavior.

[50]BCBSNC Health Care Reform Preventive Services Coding Guide https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/bcbsnc_hcr_preventive_services.pdf

- The service can be provided to individuals with multiple sex partners, those who are using barrier protection inconsistently, those who were having sex under the influence of alcohol or drugs, those who were having sex in exchange for money or drugs, those who are aged 24 years or younger and sexually active for women with chlamydia and gonorrhea, those who have had an STI within the past year, persons who inject drugs (hepatitis B only), and men who are having sex with men.
- Medicare has specific restrictions regarding the provider and the setting. However, most other payers include this service in their Preventive Care Services Coverage Policy without restriction to provider and place.
- For Medicare, the service must be provided by a Medicare-eligible primary care provider in a primary care setting. See Medicare NCD below.
- These codes could be used for HIV negative or positive individuals.

Chronic Care Management Services

Chronic care management (CCM) codes have been in place since 2015 and have been updated and expanded. CMS[51] and many other payers allow reimbursement for these CCM services. However, restrictive requirements and difficulties in providing chronic care management are such that very few practices are attempting to do it. It is described below for the sake of completeness in this guide, but will likely be used infrequently. For PrEP, these services may include PrEP adherence management and counseling, provision of linkage and referral services for other healthcare and social services, and management of any complex or chronic condition that the PrEP patient may have in addition to any PrEP management services.

Care Management Services

These outpatient codes are cumulative monthly codes. Documentation of Per CPT®, chronic care management services are services provided to patients who have medical and/or psychosocial needs requiring establishing, implementing, and monitoring a care plan. In order for a patient to qualify for these services, there must be CCM services, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Provided by clinical staff supervised and directed by a physician or other qualified health care professional[52]

99490 - First 20 minutes of clinical staff time per calendar month
99439 - Each additional 20 minutes of clinical staff time per calendar month (List separately in addition to code for the primary procedure, 99490)

Provided personally by a physician or other qualified health care professional

99491- First 30 minutes per calendar month
99437 - Each additional 30 minutes per calendar month (List separately in addition to code for the primary procedure, 99491)

[51]CMS Medicare Learning Network has publish a comprehensive Chronic Care Management Services Guide here https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

[52]Per CPT® a qualified health care professional "is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service."

How to use these codes:

- The practice must implement a care plan that addresses the patient's conditions, and a clinical staff member must spend 20 minutes during a calendar month coordinating care and communicating with the patient.
- The physician, APRN, or PA develops a care plan, which is stored electronically. Everyone whose minutes "count" towards the 20 clinical staff minutes/month must have access to the care plan.
- Other key healthcare professionals must have electronic access to care plans; fax is insufficient as a means of communicating.
- A copy of the care plan is provided to the patient, electronically or on paper.
- The electronic record must include a full list of problems and medications and should facilitate caring for the patient during care transitions.
- Medication reconciliation is required as part of the service.
- The patient must have access to care and health information 24 hours per day, seven days per week
- One provider must be designated for continuity of care.

Care management includes assessment of the patient's medical, functional, and psychosocial needs; managing care transitions; and coordination with home and community services.

How to get started:

- The service must be implemented at a "comprehensive" E&M service (wellness visit or problem oriented service)
- Informed consent is required before starting the service. The practice must inform the patient that they will provide this service and get written consent from the patient to do so and to share information with other providers.
- The practice must also inform that patient that they can revoke this consent and stop receiving CCM services at any time.
- Document these communications in the record and give the patient a written or electronic copy of the care plan.
- May not count any clinical staff time on a day when the physician or qualified healthcare professional (e.g., APRN, PA) has an evaluation and management service with the patient.

Supervision of clinical staff is general, not direct, supervision. That means the billing provider does not need to be in the office when the clinical staff provides the non-face-to-face* care. The group may only report this service during the month in which the clinical staff has 20 minutes of non-face-to-face time with the patient.

- The term "non-face-to-face" used by CMS in the requirements above has been described as "activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers"

Principal Care Management Services

CPT® issued four new codes in 2022 as a part of the Chronic Care Management category. These codes are Principal Care Management (PCM) codes which replaced Medicare-issued G codes, G2064 and G2065. They differ from the previously discussed Chronic Care management codes in that they do not require multiple chronic conditions. The codes represent services focusing on the medical or psychological needs manifested by a single, complex chronic condition expected to last at least three months.

While Chronic Care Management pertains to managing multiple chronic conditions, PCM services are refined in scope to the treatment of an isolated chronic condition. For PrEP this may include PrEP adherence management and counseling, provision of linkage and referral services for other healthcare

and social services, and management of a single chronic condition managed by the same provider who is providing the PrEP services.

The full CPT® description states that PCM services, for a single high-risk disease have the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires development, monitoring, or revision of a disease-specific care plan
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
- ongoing communication and care coordination between relevant practitioners furnishing care

When PCM is provided by clinical Staff supervised and directed by a physician or other qualified health care professional:

99426 - First 30 minutes of clinical staff time per calendar month
99427 - Each additional 30 minutes of clinical staff time per calendar month (List separately in addition to code for the primary procedure, 99426)

When PCM is provided personally by a physician or other qualified health care professional

99424- first 30 minutes per calendar month
99425 - Each additional 30 minutes per calendar month (List separately in addition to code for the primary procedure, 99425)

For CMS, the documentation and record keeping requirements for PCM codes is consistent with the Chronic Care Management codes.

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

The USPSTF recommends screening for alcohol misuse and behavioral interventions for individuals whose screening results are positive. CMS covers this service, but with limitations on which provider types can perform and be paid for the service. State Medicaid programs can individually decide whether or not to restrict coverage based on specialty designation of the provider.

This service code was originated by Medicare as discussed in the Medicare Specific Codes section of this guide. It has been included here to highlight the fact that this code has been adopted by many commercial payers.

If in the course of providing PrEP services, the provider determines that the patient would benefit from alcohol misuse screening and counseling, these codes may be reported. Always confirm that the payer in question recognizes and covers these codes:

G0442 Annual alcohol misuse screening, 5 to 15 minutes
G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Counseling is furnished by qualified physicians, APRNs, and PAs in a primary care setting. The services are outpatient services and may take place at any of the outpatient locations referenced earlier in this guide. These services may be provided to patients regardless of their HIV status.

CMS will cover annual alcohol screening and up to four, brief face-to-face behavioral counseling interventions in primary care settings to reduce alcohol misuse. State Medicaid programs and private payers may have their own rules and frequency limitations.

CMS does not identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Various screening tools are available for screening for alcohol misuse.

Each of the four behavioral counseling interventions must be consistent with the "5As" approach that has been adopted by the USPSTF to describe such services:

Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Care Coordination by Community Health Workers in Non-traditional Healthcare Settings

As mentioned in the introduction of this guide, government healthcare payers and private insurance companies pay for services performed by licensed professionals in medical settings. This is an obstacle for payment for health departments and public health clinics that employ community health workers (CHW), peers, and other non-licensed staff for outreach and linkage services. On July 15, 2013, CMS changed a rule related to Medicaid coverage of preventive services in a non-traditional setting, provided by non-licensed staff members. This rule allows for state Medicaid programs to pay for preventive services provided by a non-licensed professional when the services are recommended by a physician, APRN, or PA. The definition of preventive services did not change. A CMS document describes these services as those that involve direct patient care and for the express purpose of diagnosing, treating or preventing illness or injury or other impairments to an individual's physical or mental health.

This may allow CHWs or other non-licensed professionals to perform and bill Medicaid for services that would typically only be billed by physicians, APRNs, or PAs. However, it requires that each individual state Medicaid program apply to CMS in order to be eligible to cover the services in this way. State health departments and public health clinics must query their own state Medicaid agency to determine if their state Medicaid has made this application to CMS.

For PrEP, these codes may expand the staff for whom counseling, education, and training become billable events. If approved by the state in which the service is provided, these self-management education and training codes that can be billed by CHWs. Although coverage will vary by state Medicaid programs these will likely include self-management education and training. The CHWs must be supervised by a physician, APRN, or PA depending on the state.

98960: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes for an individual patient

98961: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes for 2-4 patients

98962: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes for 5-8 patients

Check with your state Medicaid program and private insurers regarding each payer's policy on who may provide these self-management training services. These codes are billed per patient when in groups.

- In the Medicare fee schedule, these three codes have a status indicator of "bundled." That means that Medicare will not cover them, and many private insurers may not pay for these either. However, if a state Medicaid program has opted to expand their coverage of preventive services and received permission from CMS these codes could be used by community health workers or other non-licensed professionals.

Targeted Case Management

In many cases, it is a CHW who is reaching out to individuals to encourage screening, to support the initiation of PrEP, and to support the continued PrEP treatment. The work of CHWs is critical, but too often, their work is not recognized and paid by insurance companies. There are HCPCS codes for this work, which are developed by CMS for its own use, but the codes are often also recognized by state Medicaid programs and commercial payers.

T1017 Targeted case management, each 15 minutes

T1017 may be reported by case managers. For PrEP, this may represent linkage to medical services, social services, and financial services. Verify coverage through the Medicaid program and ensure that the provider of the services is licensed appropriately and enrolled.

Although CMS developed this code, Medicare does not recognize it or set a fee for it. However, some state Medicaid programs do recognize and pay for the service performed by a CHW. Texas has created a new provider type for local health departments (LHDs)[53]. Beginning in February 2023, LHD providers are able to bill and be paid for service code T1017. Each state Medicaid program sets its own policies and payment amounts. Groups and organizations that are providing these services will need to check with their own state Medicaid program about coverage of this case management. While most states and commercial payers require a chronic condition diagnosis for use of targeted case management services, these services could be provided and include PrEP case management if a person meets the definition for a chronic condition and is also using PrEP.

This is a case management service and may be performed by CHWs.

Check with the state Medicaid programs to determine the places of service in which this code is allowed. Document time in the medical record.

[53]New Provider Type for Local Health Departments Effective December 31, 2022 Effective December 31, 2022, a separate provider type (PT) will be available for Medicaid enrollment of local health departments (LHDs), including health service regional offices that operate in the capacity of LHDs.

Establishing a separate PT for LHDs will permit these providers to enroll and bill for Medicaid services within their scope of practice.

All current providers enrolled in Medicaid that qualify for LHD services must enroll as an LHD.

The types of services LHD providers will be rendering include immunization services and the screening and treatment for sexually transmitted infections and infectious diseases.http://www.tmhp.com/news/2022-12-22-new-provider-type-local-health-departments-effective-december-31-2022

XI.

Denials, Appeals, and Corrected Claims

There are three possible outcomes for a claim submitted and accepted by a payer.

1. The claim was processed as expected and paid with accurate deductible and appropriate cost-share applied.
2. The claim was denied with no payment to the provider and no cost-share to the patient.
3. The claim was paid, but the payment amount or the patient cost-share/deductible did not process as expected.

If a claim is denied or not processed as expected, information on the claim must be changed or the denial must be accepted. Merely resubmitting the claim without changes or additional information will not produce a different result. There are two ways to provide additional information to the payer: a corrected claim or an appeal. When additional information **can be** provided to the payer within the fields of the claim form, a corrected claim can be submitted. When additional information **cannot be** provided within the fields on the claim form, then a letter with documentation supporting the appeal rationale must be submitted. A phone call to the payer is the best route to accurate payer-specific guidance.

Each payer dictates the time frame within which an appeal or corrected claim may be submitted. These timely filing limits are strictly enforced by the payer. It is rare that filing limit exceptions are granted.

When appealing a payer claim determination, locate and read the payer policy to determine if that payer has a published medical policy for the service being appealed. The basis of the appeal or redetermination request must address the substance of the medical policy as well as standard coding conventions and clinical practice.

Appeal Guidance for Common PrEP Claim Issues

Corrected Claims and Appeals

The most commonly occurring denial reasons for inaccurately processed claims are listed below. Circumstances may exist that allow for multiple routes to overturning a denial. Corrected claims are the most streamlined option to have a claim reprocessed. If an appeal letter is necessary, insert the applicable appeal paragraph into the appeal letter templates at the end of this section. Every appeal letter must contain at a minimum three elements: identify the claim and/or the specific code being appealed, state the basis on which the denial should be overturned (official resources are very helpful), and state very specifically what action is expected of the payer, e.g., make additional payment, reprocess with no patient deductible or cost-share etc.

Common Reasons for Denial

Denial Reason	Corrective Action
The test was done in a setting in which a bundled payment was negotiated for the service, and the screening is not included in the negotiated rate.	If the contract for organization or department is confirmed to bundle lab work into an all-inclusive or negotiated rate, then no action is necessary. If labs are not bundled, see contracting for assistance with contract wording for appeals.
The patient is already diagnosed with the condition and no longer needs to be screened for the illness.	A screening service will not be paid for a patient with a previously diagnosed condition.
An incorrect diagnosis is reported.	Locate and read payer policies for correct reporting diagnosis code. If applicable to this patient encounter, change or re-order the codes and submit a corrected claim.
The payer has met the frequency limits for the service	Review the interval of the denied service. If the interval is less than the recommended guidance, no payment will be made. If it is at or greater than the recommended interval, request a payer review to determine the ordering provider or group. Check both the coverage guidance issued by the plan and the CDC PrEP guidelines. If the plan's guidance is more restrictive than the CDC guidelines, notify the plan they may be out of compliance with federal requirements.
Modifier 33 was not appended to the CPT® or HCPCS code.	Append Modifier 33 to the USPSTF Grade A or B service and submit a corrected claim.
Modifier 33 was appended to the CPT® or HCPCS code but the payer does not accept it	Remove Modifier 33 from the denied service line and submit a corrected claim.

Denial: Procedure Code/Gender Mismatch

Service Affected: Chlamydia or gonorrhea testing of a male

Corrected Claim

Modifier KX

Modifier KX may be used if the client is a transgender male, then appending Modifier KX and submitting a corrected claim should result in a paid claim. Modifier KX is a multi-use modifier that will override payer systems edits when a procedure or diagnosis code is not typically associated with the gender of the client.

Appeal Letter

CPT code [XXXXX – Description], does not have any gender restrictions in the AMA's CPT® and is therefore not subject to gender edits.

Additionally, this laboratory service is part of a PrEP protocol. The US Public Health Service publication, Pre-Exposure Prophylaxis for the Prevention of HIV Infection in the United States - 2021 Update, clinical guidance states both chlamydia and gonorrhea testing are recommended for male and female patients. Specifically, it states *"Tests to screen for gonorrhea are recommended for **all sexually active adults** prescribed PrEP, both at screening, for MSM at quarterly visits, and for women at semi-annual visits. Tests to screen for chlamydia are recommended for all sexually active MSM prescribed PrEP, both at screening prior to initiation and at quarterly visits."*

Denial: Payment adjusted because the payer deems the information submitted does not support this many services on one date of service.

Service affected: Chlamydia and Gonorrhea testing (three-site testing) when more than one specimen is tested on a single patient on a single date of service.

Corrected Claim

Check with the payer-specific guidance for submitting multiple units of the same test for the same patient on the same day. Some payers will process it on one line with three units. Others require the test to be submitted on multiple lines.

If the payer allows for multiple units on one line and the claim has not paid for three units, then refer to the appeal letter section below.

If the payer does not allow for multiple units on one line, send a corrected claim with a CPT® on each of the three lines. The first line will have the CPT® only, the second and third lines will have the CPT® plus Modifier 59. Modifier 59 will indicate that the test was performed on distinct specimens.

Appeal Letter

Please reprocess this claim to pay two (or whatever the appropriate number is) additional units of this claim. CMS has published Medically Unlikely Edits (MUE) as a part of the National Correct Coding Initiative (NCCI). MUEs describe the maximum units of service that a provider may report under most circumstances for a single patient on a single date of service. [CPT code 87591 has an MUE value of three and CPT code 87491 has an MUE of three. Insert the code and MUE value here].

If the denial relates to multiple units of 8491 and 87591 specifically, consider using the following text in addition to the MUE rationale.

We are specifically appealing the payment of 87491 (chlamydia) and 87591 (gonorrhea) in which only 1 unit was paid for each CPT code. These codes were billed for 3 units as there were 3 collection sites (oral, urine, and anal) for each test. For gonorrhea and chlamydia testing, NAAT (nucleic acid amplification test) tests are preferred because of the greater sensitivity. Oral, rectal, and urine specimens are collected via 3-site testing, or extra-genital testing, to maximize the identification of infection at site of exposure.

Please reprocess this claim to pay two (or whatever the appropriate number is) additional units of this claim.

Denial: Payment adjusted because the payer deems the information submitted does not support the frequency of services.

Service Affected: Laboratory services when the frequency with which the labs are performed is more frequent than the payer medical policy allows.

Corrected Claim

Although it is possible, adding a Modifier 33 to the claim if it was not present at first submission, may allow the claim to bypass frequency and cost-share edits in the payer system. However, it is more likely to have success overturning this type of denial with the appeal letter template below.

Appeal Letter

The service represented by (CPTs®), was performed as a part of the Pre-Exposure Prophylaxis (PrEP) for HIV Prevention protocol. Based on the CDC clinical practice guidelines for PrEP, Table 1a (or 1b) indicates that the service is recommended every [Choose and insert the correct frequency from tables 1a and 1b in the CDC document linked above]. The USPSTF Grade A recommendation mandates coverage of this service at the frequency stated by the CDC publication. Additionally, these labs are required every 3 months per the FDA black box warning for the PrEP medication being taken by the patient as well as the USPSTF.

Please reprocess this claim and pay this service with no cost-share to the patient as this is an integral part of a USPSTF Grade A preventive service.

Table 1a: Summary of Clinician Guidelines for Daily Oral PrEP Use

	Sexually-Active Adults and Adolescents[1]	Persons Who Inject Drug[2]
Identifying substantial risk of acquiring HIV infection	Anal or vaginal sex in past 6 months AND any of the following: • HIV-positive sexual partner (especially if partner has an unknown or detectable viral load) • Bacterial STI in past 6 months[3] • History of inconsistent or no condom use with sexual partner(s)	HIV-positive injecting partner OR Sharing injection equipment
Clinically eligible	**ALL OF THE FOLLOWING CONDITIONS ARE MET:** • Documented negative HIV Ag/Ab test result within 1 week before initially prescribing PrEP • No signs/symptoms of acute HIV infection • Estimated creatinine clearance ≥30 ml/min[4] • No contraindicated medications	
Dosage	• Daily, continuing, oral doses of F/TDF (Truvada®), ≤90-day supply OR • For men and transgender women at risk for sexual acquisition of HIV; daily, continuing, oral doses of F/TAF (Descovy®), ≤90-day supply	
Follow-up care	**Follow-up visits at least every 3 months to provide the following:** • HIV Ag/Ab test and HIV-1 RNA assay, medication adherence and behavioral risk reduction support • Bacterial STI screening for MSM and transgender women who have sex with men[3] – oral, rectal, urine, blood • Access to clean needles/syringes and drug treatment services for PWID **Follow-up visits every 6 months to provide the following:** • **Assess renal function for patients aged ≥50 years or who have an eCrCl <90 ml/min at PrEP initiation** • **Bacterial STI screening for all sexually-active patients[3] – [vaginal, oral, rectal, urine- as indicated], blood** **Follow-up visits every 12 months to provide the following:** • Assess renal function for all patients • Chlamydia screening for heterosexually active women and men – vaginal, urine • For patients on F/TAF, assess weight, triglyceride and cholesterol levels	

Table 1b: Summary of Clinician Guidance for Cabotegravir Injection PrEP Use

	Sexually-Active Adults	Persons Who Inject Drugs[1]
Identifying substantial risk of acquiring HIV infection	Anal or vaginal sex in past 6 months AND any of the following: • HIV-positive sexual partner (especially if partner has an unknown or detectable viral load) • Bacterial STI in past 6 months[7] • History of inconsistent or no condom use with sexual partner(s)	HIV-positive injecting partner OR Sharing injection equipment
Clinically eligible	**ALL OF THE FOLLOWING CONDITIONS ARE MET:** • Documented negative HIV Ag/Ab test result within 1 week before initial cabotegravir injection • No signs/symptoms of acute HIV infection • No contraindicated medications or conditions	
Dosage	• 600 mg cabotegravir administered as one 3 ml intramuscular injection in the gluteal muscle o Initial dose o Second dose 4 weeks after first dose (month 1 follow-up visit) o Every 8 weeks thereafter (month 3,5,7, follow-up visits etc)	
Follow-up care	**At follow-up visit 1 month after first injection** • HIV Ag/Ab test and HIV-1 RNA assay **At follow-up visits every 2 months (beginning with the third injection – month 3) provide the following:** • HIV Ag/Ab test and HIV-1 RNA assay • Access to clean needles/syringes and drug treatment services for PWID **At follow-up visits every 4 months (beginning with the third injection- month 3) provide the following:** • Bacterial STI screening[2] for MSM and transgender women who have sex with men[2] – oral, rectal, urine, blood **At follow-up visits every 6 months (beginning with the fifth injection – month 7) provide the following:** • Bacterial STI screening[1] for all heterosexually-active women and men – [vaginal, rectal, urine - as indicated], blood **At follow-up visits at least every 12 months (after the first injection) provide the following:** • Assess desire to continue injections for PrEP • Chlamydia screening for heterosexually active women and men – vaginal, urine **At follow-up visits when discontinuing cabotegravir injections provide the following:**	

Non-Compliant Application of Cost-Share

The most frequently encountered claim processing error for PrEP claims is the non-compliant application of cost-share. As a USPSTF Grade A service, the patient should not be billed or held liable for any deductible, co-insurance, or co-pays.

When a PrEP service is paid but a cost-share is applied to patient liability, the provider or the patient may appeal that determination. NASTAD has published a PrEP Cost Sharing Template to reference when submitting appeals. This template may be shared with and used by the patient to appeal the same claim.

Denial Types

If the claim was not submitted and processed with modifier 33, see the Common Reasons for Denial table at the beginning of this section.

If the claim was submitted with modifier 33, the claim still may have been processed with the appropriate amount paid to the provider, but the cost-share and deductible left the patient with an improper financial responsibility. Use the following appeal letter as a basis for that reconsideration request.

Appeal Letter

The services referenced in this claim are associated with pre-exposure prophylaxis (PrEP), a covered preventive service. Therefore, applying cost share and deductible amounts to the patient for these services is in violation of the Affordable Care Act (ACA) protections. The payer and plan through which the above-stated patient is subject to ACA preventive services coverage and cost-sharing protections.

As such, it is subject to the ACA's Essential Health Benefits requirements, including the preventive services coverage and cost-sharing provisions codified at 42 USC §300gg–13 and 29 CFR § 2590.715-2713. Under these provisions, non-grandfathered group health plans are required to cover

services with a Grade A or B from the U.S. Preventive Services Task Force (USPSTF) without cost sharing, starting no later than the plan year beginning one year after the final recommendation. In June of 2019, the USPSTF gave PrEP the final Grade A recommendation. In July 2021, the Departments of Labor, Health and Human Services, and Treasury issued guidance for plans on the implementation of the coverage and cost-sharing requirements. The guidance clarifies that in addition to providing access to the PrEP medication without cost sharing, plans also must cover the following ancillary services without cost sharing:

- HIV testing, including HIV-1 RNA testing (at initiation and every three months consistent with CDC guidelines)
- Hepatitis B and C testing (at initiation and periodically consistent with CDC guidelines)
- Creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR) (at initiation and periodically consistent with CDC guidelines)
- Sexually transmitted infection screening and counseling (at initiation and periodically consistent with CDC guidelines, including three-site anatomic testing [insert the three sites tested here] for gonorrhea and chlamydia and testing for syphilis, together with behavioral counseling)
- Adherence counseling (at initiation and regularly consistent with CDC guidelines)
- Office visits associated with each recommended preventive service when the primary purpose of the office visit is the delivery of the recommended preventive service.

Please reprocess this claim to eliminate any patient deductible, co-insurance, or co-payment liability.

Denial for CPT code and Modifier mismatch

CPT codes submitted with a Modifier 33 on a claim may be denied with the reason code that states, "The procedure code is inconsistent with the modifier used" or the remark code "Invalid combination of HCPCS modifiers". Most frequently, this denial occurs with laboratory services that are not typically reported as screening or preventive services.

This appeal is similar to the cost-share appeal in that the payer has failed to recognize integral PrEP components as covered under the USPSTF and ACA coverage and cost-share protections. The appeal rationale is the description of the services

Appeal Letter

The services referenced above on this claim are associated with pre-exposure prophylaxis (PrEP), a covered preventive service as recommended by the USPSTF and the CDC. The services considered as integral components of PrEP based on these recommendations have been identified with a Modifier 33 on the claim.

Insert CPT code [XXXXX – Description] detail here. [test name] is one of the recommended and approved components of the PrEP Protocol which has been granted a Grade A from the USPSTF.

Therefore, denying this service is in violation of the Affordable Care Act (ACA) protections. The payer and plan through which the above-stated patient is subject to ACA preventive services coverage and cost-sharing protections.

As such, it is subject to the ACA's Essential Health Benefits requirements, including the preventive services coverage and cost-sharing provisions codified at 42 USC §300gg–13 and 29 CFR § 2590.715-2713. Under these provisions, non-grandfathered group health plans are required to cover services with a Grade A or B from the U.S. Preventive Services Task Force (USPSTF) without cost sharing, starting no later than the plan year beginning one year after the final recommendation.

In June of 2019, the USPSTF gave PrEP the final Grade A recommendation. In July 2021, the Departments of Labor, Health and Human Services, and Treasury issued guidance for plans on the implementation of the coverage and cost-sharing requirements. The guidance clarifies that in addition to providing access to the PrEP medication without cost sharing, plans also must cover the following ancillary services without cost sharing:

[the service in question may be isolated and sent without referencing the other PrEP services or the service in question may be emphasized in bold or highlight.]

- HIV testing, including HIV-1 RNA testing (at initiation and every three months consistent with CDC guidelines)
  - Hepatitis B and C testing (at initiation and periodically consistent with CDC guidelines)
  - Creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR) (at initiation and periodically consistent with CDC guidelines)
  - Sexually transmitted infection screening and counseling (at initiation and periodically consistent with CDC guidelines, including three-site anatomic testing [insert the three sites tested here] for gonorrhea and chlamydia and testing for syphilis, together with behavioral counseling)
  - Adherence counseling (at initiation and regularly consistent with CDC guidelines)
  - Office visits associated with each recommended preventive service when the primary purpose of the office visit is the delivery of the recommended preventive service.

Please reprocess this claim to pay the service without any patient deductible, co-insurance, or co-payment liability.

SAMPLE Appeal Letter Templates[54]

Template for a claim that has been denied with no payment

[Organization Name]
[Organization Address]
[Organization Provider #]
[Provider Name – if applicable]
[Provider # - if applicable]

Date

Address of the Health Plan's Appeal Department
Re: Name of Insured
Plan ID#:
Claim #:

To Whom It May Concern:
I am writing to request a review of your denial of the claim for treatment or services provided by [Organization or Provider name] on [date of service].

The reason for the denial was listed as (reason listed for denial). We have reviewed your payer policy, standard coding and billing convention, and believe the service should be covered.

[Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording. If you're including documents, include a list of what you're sending here. Insert applicable rationale from the denial appeal list below. State explicitly what you want the payer to do. i.e., Please reprocess this claim for the full allowable payment with no patient cost-share]

I can be reached at the telephone number and/or e-mail address listed below if you need additional information. I look forward to receiving your response as soon as possible.

Sincerely,
Signature
Typed Name
Telephone Number
Email address

Template for a claim that has been paid but the claim has been processed incorrectly. The error may be a payment lower than expected, a payment based on an incorrect cost share allocation.

[Organization Name]
[Organization Address]
[Organization Provider #]
[Provider Name – if applicable]
[Provider # - if applicable]

Date

Address of the Health Plan's Appeal Department

Re: Name of Insured
Plan ID#:
Claim #:
Date of Service:

To Whom It May Concern:

I am writing to request a review of an erroneously adjudicated claim for treatment or services provided by [Organization or Provider name] on [date of service].

Although this claim was paid, it was not adjudicated as expected. We have reviewed your payer policy, standard coding and billing convention, and federal ACA mandates and have concluded that the claim should be reprocessed.

[Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording. If you're including documents, include a list of what you're sending here. Insert applicable rationale from the denial appeal list below if available]

Please reprocess this claim for *[additional payment or additional payment and correction of the patient cost share]*. I can be reached at the telephone number and/or e-mail address listed below if you need additional information. I look forward to receiving your response as soon as possible.

Sincerely,
Signature
Typed Name
Telephone Number
Email address

XII.

PEP

PEP for HIV prevention means taking HIV medication within 72 hours (3 days) after possible exposure to HIV to prevent HIV infection. Although this course of treatment strives to prevent HIV infection, it is not considered a preventive service because possible exposure to HIV has occurred. As such PEP does not have the USPSTF A grade and ACA coverage and protections as PrEP does.

PEP for HIV prevention is considered a treatment for possible exposure to HIV. As such, both the CPT® code and the ICD-10 code must be problem-oriented by definition. Initial presentation of the exposure may occur in a variety of traditional and non-traditional settings.

For PEP-related visits, there are two common settings in which the initial visit may occur. Use this PEP visit decision tree to determine which code set is most appropriate. PEP counseling services at initiation and for follow-up counseling and adherence may be reported using problem-oriented E&M codes.

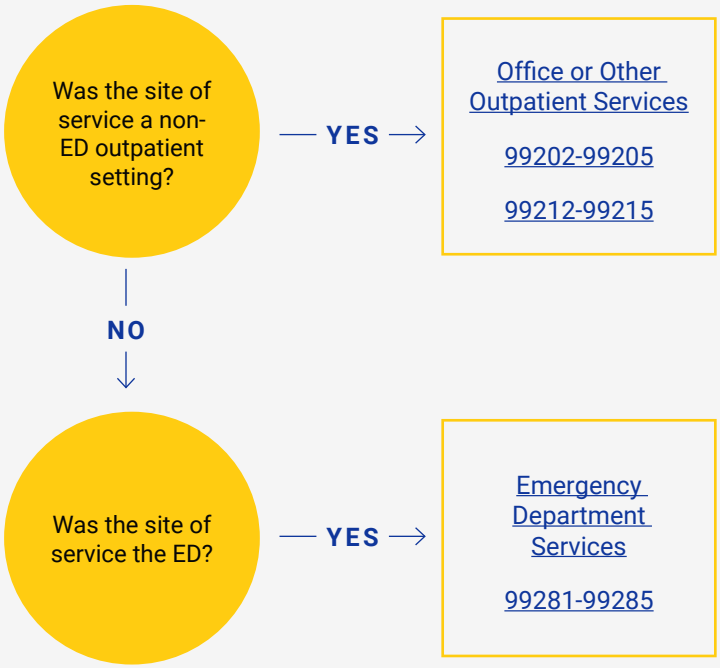
CPT® describes services by type of service and at times by location of service. This guide addresses outpatient services only. Outpatient medical visits associated with PEP may take place in the ED. New or established patient ED services are represented by a specific code set. (99281-99285). All other outpatient visit services referenced in this guide refer to but are not limited to the following locations:

- Physician office
- Outpatient hospital
- Clinic
- Federally Qualified Health Center (FQHC)
- Rape crisis center
- Departments of health
- School clinic
- Mobile clinic
- Urgent care facility
- Campus clinic
- State or local agency hotlines[55] (initial call may constitute a telehealth visit if billable)
- Community health center

Unless otherwise specified within this guide, all **visit** codes referenced must be performed by a licensed and enrolled practitioner. Licensing requirements vary from state to state. Enrollment and supervision requirements vary from payer to payer. Compliance with licensing, supervision, and enrollment requirements is the responsibility of the organization in which the service is performed.

[55]New York has created a funded PEP hotline.

PEP Outpatient E&M Encounter Decision Tree



PEP Visits

PEP Office/Outpatient Medical Visits

Initial encounters for PEP may occur during a problem-oriented visit in a physician's office or other outpatient setting.

New Patient	Time Range in minutes	Established Patient	Time Range in minutes
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54

How to report these codes:

- Choose codes based on the new versus established status of the patient and total time spent on the date of the encounter.
- These codes are problem-oriented codes and are therefore not preventive codes and as such are not subject to ACA cost-share protections.
- Report problem-oriented ICD-10 codes with these CPT® codes. See PEP ICD-10 code recommendations in this guide.

PEP Emergency Department Services

The initial encounter for PEP may occur in the ED of a hospital.

The ED service codes are considered problem-oriented. Per CPT®, "time is not a descriptive component for the emergency department levels of E&M services because ED services are typically provided on a varying intensity basis, often involving multiple encounters with several patients over an extended period of time." No distinction is made between new and established patients. The determining factor in ED code choice is the level of medical decision-making, noted in bold below.

CPT® Code	Description
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision-making.
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **low** medical decision-making.
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** medical decision-making.
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high** medical decision-making.

How to report these codes:

- These ED Codes are problem-oriented codes.
- These ED service codes are not preventive codes and as such are not subject to ACA cost-share protections.
- Report problem-oriented ICD-10 codes with these CPT® codes. See PEP ICD-10 code recommendations in this guide.

Although not recommended to report PEP services, some programs[56] and payers have indicated that Preventive Medicine Counseling codes should be reported for PEP encounters.

[56]The Public Health Department of Los Angeles County published this guidance for PrEP & PEP billing codes http://publichealth.lacounty.gov/dhsp/Providers/PrEP-PEPBillingCodes.pdf

Preventive Medicine Counseling

These preventive medicine codes are intended to be used in the absence of an established diagnosis, to promote health, to prevent illness, and for risk factor reduction. It would be appropriate to use these codes for risk factor reduction and promoting health in the absence of an illness or injury.

CPT® Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an **individual** (separate procedure), approximately 15 minutes
99402	approximately 30 minutes
99403	approximately 45 minutes
99404	approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a **group** setting (separate procedure), approximately 30 minutes
99412	approximately 60 minutes

How to report these codes:

- As with all time-based codes, document the time of the face-to-face counseling in the medical record and describe the counseling. If these codes are reported with other time-based codes, documentation of the time for each service is required. No overlap of time is allowed when determining reportable codes.
- See PEP ICD-10 code recommendations in this guide.
- Very few payers have adopted this code for PEP visits. Use only if payer-specific PEP guidance affirms.
- Payer Notes: Some payers may limit benefit coverage to only a subset of these codes. Refer to the payer policy to determine CPT® code coverage. Indiana Medicaid (IHCP)[57] lists only 99401 as a payable code.

PEP Labs

The CDC PEP guidelines recommend laboratory tests and frequency for initiation and monitoring. These lab tests must be ordered by a physician, APRN, or PA. Some of the tests recommended for PEP have been granted an A grade by the USPSTF including HIV, STIs, lipids, Hepatitis B, and Hepatitis C. If the interval at which the labs are ordered and performed is shorter, even by one day, the lab may be denied for frequency violation. The intervals allowed for the lab services are benefits that are associated with the patient, not the provider. If another provider has ordered or performed this lab test within the prescribed time, additional services may be denied.

Modifiers for use when reporting laboratory services for CDC preferred PEP regimen.

[57]The Indiana Health Coverage Programs (IHCP) publishes reimbursement information regarding all Common Procedural Terminology (CPT©), Healthcare Common Procedure Coding System (HCPCS), recognized by the IHCP through the following fee schedules. https://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp

Modifier	Description
92	**Alternative Laboratory Platform Testing:** When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber
59	**Distinct Procedural Service** indicates that a procedure is separate and distinct from another procedure on the same date of service. For lab services that may mean the same test on different specimens.
QW	Clinical Laboratory Improvement Amendment (CLIA) waived test[58]

The laboratory CPT® codes included in this section of the guide are a comprehensive list for each disease category. Payer medical policy may require the use of certain codes to provide benefits. For example, CDC guidelines list recommended hepatitis B tests, but tests for all methodologies have been included. Some G codes, temporary codes issued by CMS, have been included in this list as commercial payers are permitted to adopt these codes. **The codes in bold for each category are the more commonly used codes for PEP initiation and monitoring**. However, the decision regarding tests ordered remains with the clinician

[58]CLIA Waived Tests require Modifier QW. CMS typically publishes new waived test transmittals four times per year. The latest list published in June 2023 effective 10/2/2023 can be found here https://www.cms.gov/files/document/r12089cp.pdf

CDC Guidelines for PEP[59]

Table 2 - Recommended schedule of laboratory evaluations of source and exposed persons for providing nPEP with preferred regimens

	Baseline	Baseline	4–6 weeks after exposure	3 months after exposure	6 months after exposure
		For all persons considered for or prescribed nPEP for any exposure			
HIV Ag/Ab testing [a] (or antibody testing if Ag/Ab test unavailable)	✓	✓	✓	✓	✓ [b]
Hepatitis B serology, including: hepatitis B surface antigen hepatitis B surface antibody hepatitis B core antibody	✓	✓			✓ [c]
Hepatitis C antibody test	✓	✓			✓ [d]
		For all persons considered for or prescribed nPEP for sexual exposure			
Syphilis serology [e]	✓	✓	✓		✓
Gonorrhea [f]	✓	✓	✓ [g]		
Chlamydia [f]	✓	✓	✓ [g]		
Pregnancy [h]		✓	✓		
			For persons prescribed tenofovir DF+ emtricitabine + raltegravir or tenofovir DF+ emtricitabine + dolutegravir		
Serum creatinine (for calculating estimated creatinine clearance [i])		✓	✓		
Alanine transaminase, aspartate aminotranferase		✓	✓		
		For all persons with HIV infection confirmed at any visit			
HIV viral load	✓	✓ [j]			
HIV genotypic resistance	✓	✓ [j]			

[59]Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016 https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

Abbreviations: Ag/Ab, antigen/antibody combination test; HIV, human immunodeficiency virus; nPEP, nonoccupational postexposure prophylaxis; tenofovir DF, tenofovir disoproxil fumarate.

[a] Any positive or indeterminate HIV antibody test should undergo confirmatory testing of HIV infection status.

[b] Only if hepatitis C infection was acquired during the original exposure; delayed HIV seroconversion has been seen in persons who simultaneously acquire HIV and hepatitis C infection.

[c] If exposed person susceptible to hepatitis B at baseline.

[d] If exposed person susceptible to hepatitis C at baseline.

[e] If determined to be infected with syphilis and treated, should undergo serologic syphilis testing 6 months after treatment

[f] Testing for chlamydia and gonorrhea should be performed using nucleic acid amplification tests. For patients diagnosed with a chlamydia or gonorrhea infection, retesting 3 months after treatment is recommended.

- For men reporting insertive vaginal, anal, or oral sex, a urine specimen should be tested for chlamydia and gonorrhea.
- For women reporting receptive vaginal sex, a vaginal (preferred) or endocervical swab or urine specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive anal sex, a rectal swab specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive oral sex, an oropharyngeal swab should be tested for gonorrhea.

[g] If not provided presumptive treatment at baseline, or if symptomatic at follow-up visit.

[h] If woman of reproductive age, not using effective contraception, and with vaginal exposure to semen.

[i] eCrCl = estimated creatinine clearance calculated by the Cockcroft-Gault formula; eCrClCG = [(140 − age) x ideal body weight] ÷ (serum creatinine x 72) (x 0.85 for females).

[j] At first visit where determined to have HIV infection.

HIV screening

The codes in bold for each category are the more commonly used codes for PEP initiation and monitoring However, the decision regarding tests ordered remains with the clinician.

CPT® Code	Description
87806	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies
86689	HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	Antibody, HIV-1
86702	Antibody, HIV-2
86703	Antibody, HIV-1 and HIV-2, single result
	(For HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result, use 87389)
87904	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1, each additional drug tested (List separately in addition to code for primary procedure)
	(When HIV immunoassay [HIV testing 86701-86703 or 87389] is performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual code)

Infectious agent detection by nucleic acid (DNA or RNA);	
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed
87536	HIV-1, quantification, includes reverse transcription when performed
87357	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique, includes reverse transcription when performed
87539	HIV-2, quantification, includes reverse transcription when performed
Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method	
87389	**HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result**
87390	HIV-1
87391	HIV-2
For Medicare patients	
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique
G0435	Infectious agent antibody detection by rapid antibody test.
G0475	HIV antigen/antibody, combination assay, screening

Screening for Hepatitis B

CPT® Code	Description
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
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	
87340	**hepatitis B surface antigen (HBsAg)**
87341	hepatitis B surface antigen (HBsAg) neutralization
87467	hepatitis B surface antigen (HBsAg), quantitative

Screening for hepatitis C

CPT® Code	Description
86803	**Hepatitis C antibody**
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot)
G0472	Hepatitis C antibody screening, for individuals at high risk and other covered indication(s)

Screening for syphilis

CPT® Code	Description
86592	Syphilis test, non-treponemal antibody, qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody, quantitative
86780	Treponema pallidum

Screening for gonorrhea

CPT® Code	Description
87590	Neisseria gonorrhoeae, direct probe technique
87591	**Neisseria gonorrhoeae, amplified probe technique**
87592	Neisseria gonorrhoeae, quantification
87850	Infectious agent antigen detection by immunoassay with direct optical observation, Neisseria gonorrhoeae

Screening for chlamydia

CPT® Code	Description
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 immunofluorescent technique chlamydia trachomatis
87490	Chlamydia trachomatis, direct probe technique
87491	**Chlamydia trachomatis, amplified probe technique**
87810	Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis

Pregnancy Testing

CPT® Code	Description
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG), quantitative
84703	Gonadotropin, chorionic (hCG), qualitative

Creatinine Clearance

CPT® Code	Description
82575	Creatinine, clearance
82565	**Creatinine, blood**
82570	Creatinine, other source

ALT & AST

CPT® Code	Description
84450	Transferase, aspartate amino (AST) (SGOT)
84460	Transferase, alanine amino (ALT) (SGPT)

PEP Drugs and Administration

The CDC recommendation for PEP includes a 28-day three-drug antiretroviral regimen.[60] There are no HCPCS codes specific to these two medications. The rendering and ordering provider bills only visit codes for counseling and any labs performed in-house. These medications are ordered by a licensed prescriber and billed by a retail or specialty pharmacy, identifying the product dispensed through NDC codes. These unique ten-digit numbers are universal product identifiers that are present on all non-prescription and prescription medication packages.

Regardless of coverage mandates, it is still critical that the provider, retail pharmacy, or specialty pharmacy is aware of payer-specific coverage requirements and limitations. Some of the more common obstacles to coverage are:

- Prior authorization
- Step Therapy: For more expensive medications some plans require an attempt at a less expensive but proven treatment first
- Certain health conditions must exist and be documented in the medical record
- Pharmacy benefit limitations or a lack of pharmacy benefits completely will contribute to cost-share decisions by the patient.

[60]See Table 5 Preferred and alternative antiretroviral medication 28-day regimens for nPEP on CDC's Guidelines: Post-Exposure Prophylaxis (PEP) https://www.cdc.gov/hiv/risk/pep/

XIII.

Appendix

The tables and lists included in this appendix are a reference for specific information included in this guide. Codes are not complete code sets. Providers and billers are advised to use full and official publications for CPT® codes and modifiers, ICD-10 diagnosis codes, HCPCS codes, and all payer policies to ensure accuracy and current status.

Glossary

Entry	Definition	Links
AMA	American Medical Association	
Appeals	Oral or written communication from a provider (or representative of the provider) to a payer to attempt to overturn a previously denied or inappropriately processed claim.	
APRN	Advanced Practice Registered Nurse	
Buy and Bill	A process by which a physician or practice can purchase medications, administer in the office, and bill directly to the payer.	
Cabotegravir	CAB is a single antiretroviral drug given as an intramuscular injection every two months to prevent HIV. Currently this is only available as a brand name drug, Apretude®	
CARC	Claim Adjustment Reason Codes: A set of standardized codes applied to a claim by a payer to provide the reason for the billed amount being different from the allowed amount.	X12 CARC
CCM	Chronic Care Management	CMS MLN Matters Chronic Care Management Article
CDC	Centers for Disease Control and Prevention CDC is the nation's leading science-based, data-driven, service organization that protects the public's health.	CDC Homepage
CHW	Community Health Workers: A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.	
CMS	Center for Medicare and Medicaid Services is the U.S. federal agency that works with state governments to manage the Medicare program, and administer Medicaid and the Children's Health Insurance program.	CMS Homepage
Corrected Claim	A replacement for a previously billed claim that requires a revision to coding, service dates or member information. The new claim must be identified as a corrected claim with the original reference number or it may deny as a duplicate of a claim already processed.	
Cost Share	This term refers to the share of costs of medical care covered by your insurance that the patient pays out of pocket. This term can include deductibles, coinsurance or copayments. It does not refer to balances due to services that are not covered.	
CPT	Current Procedural Terminology (Level I codes) are codes created by the AMA that offer a uniform language for coding medical services. CPT codes are approved by the US DHHS as the US national coding set. This code set describes the services provided to a patient.	AMA CPT information
Denial Codes	Codes assigned by a payer to a claim to indicate the reason for non-payment.	

Entry	Definition	Links
E & M	Evaluation & Management: E & M codes are CPT codes that represent services provided by a physician or other qualified and licensed healthcare professional. These services are medical and cognitive in nature which allow a provider to evaluate and manage patient health. They are codes that represent visits rather than procedures.	
Enrolled Providers	Providers for which the process of applying to a health plan or network for inclusion in their provider panels. The process often includes credentialing and contracting.	
HCPCS	Healthcare Common Procedure Coding System: (pronounced hick-picks). These are Level II HCPCS which identify products, supplies, and services not included in CPT. HCPCS codes are 5 characters, one alpha followed by four numeric.	
Health Insurance Carrier	A health insurance company. Used interchangeably with health insurance company, insurer or payer.	
HIV	Human immunodeficiency virus	
ICD-10	International Classification of Diseases, Tenth Revision. ICD-10 is the system of codes used by providers to classify signs, symptoms, illness, or injury. These codes support the medical necessity of the CPT codes which describe the service.	
Incident to	"Incident to" is a Medicare billing rule that allows a patient to be seen by a non-physician but billed under the physician's name and number. The service provided by the non-physician must be within the scope of their license and within the plan of care previously established by the physician under which the claim will be billed.	CMS MLN Matters Article "Incident to"
Medical Policies	Plan/Payer documents that indicate clinical criteria used to support coverage determinations for specific medical, surgical or dental procedures, devices, and medications. They may also indicate the billing format for claims to ensure information for successful coverage is communicated, i.e., CPT, ICD, Modifiers.	
Medicare status Indicators	Medicare assigns a status indicator to each CPT or HCPCS codes in the Medicare Physician Fee Schedule (MPFS) to signify payment status of a particular CPT or HCPCS code.	CMS MLN Matters MPFS - See page 27
Modifier	Modifiers are two-digit codes appended to the CPT or HCPCS codes to indicate that a service provided was altered by a specific set of circumstances.	Modifier Appendix
MUE	Medically Unlikely Edits Medicare established these CPT/HCPCS code limits to reduce improper payments for claims. MUEs set a maximum unit of service that a provider would report under most circumstances for a single beneficiary on a single date of service.	

Entry	Definition	Links
NASTAD	National Alliance of State and Territorial AIDS Directors. NASTAD is a leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S.	NASTAD Home Page
PA	Physician assistant	
payer	A healthcare organization that provides health coverage to members. A payer will have many plans under which members are covered.	
PEP	Post-exposure prophylaxis	
plan	A specific menu of health benefits an employer, union or other group sponsor provides to a specific group to pay for health care services.	
PrEP	Pre-exposure prophylaxis	
QHP	Qualified Health Professional	
Qualified Health Professional	Per CPT, a QHP "is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service"	
RARC	Remittance Advice Remark Codes: Codes applied by a payer in addition to the CARC to provide more detail about the denial or adjustment.	X12 RARC
Remark Codes	Codes assigned by a payer in addition to the Denial Code to provide additional information about the claim fault.	
RCM	Revenue Cycle Management. RCM is the business cycle that starts at the point of service and ends with the successful collection of payment from patients or payers. It includes registration, charge capture, coding, claim submission, remittance processing, insurance follow-up, and collections.	
Specialty Pharmacy	A pharmacy that focuses on high cost, high-touch, or limited distribution medications. It typically manages rare, chronic, and often complex medical conditions that require an increased level of patient management or counseling.	
STI	Sexually transmitted infection	
TAF/FTC	emtricitabine coformulated with tenofovir alafenamide (trade name Descovy®)	
TDF/FTC	emtricitabine coformulated with tenofovir disoproxil fumarate (trade name Truvada®)	
USPSTF	The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services	US Preventive Services Task Force

CPT® Codes

The table below is a list of all CPT® codes referenced in this guide. It is a small subset of all the codes available to report services. Refer to the full CPT® book or database for services not described in this guide.

CPT® Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure), approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure), approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure), approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure), approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure), approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure), approximately 60 minutes
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making.
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision-making.
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision-making.
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high medical decision-making.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter

CPT® Code	Description
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward level of medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient, adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient, aged 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient, aged 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; aged 65 years and older
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, adolescent (aged 12 through 17 years
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, aged 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, aged 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, aged 65 years and older

CPT® Code	Description
98970	Qualified non physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days is 5-10 minutes
98971	Qualified non physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days is 11-20 minutes
98972	Qualified non physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days is 21 or more minutes
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days is 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days is 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days is 21 or more minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment, 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment, 21-30 minutes of medical discussion
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
99490	Provided by clinical staff supervised and directed by a physician or other qualified healthcare professional, first 20 minutes of clinical staff time per calendar month
99439	Provided by clinical Staff supervised and directed by a physician or other qualified healthcare professional
99491	Provided personally by a physician or other qualified health care professional first 30 minutes per calendar month, each additional 20 minutes of clinical staff time per calendar month (List separately in addition to code for the primary procedure, 99490)
99437	Provided personally by a physician or other qualified health care professional, each additional 30 minutes per calendar month (List separately in addition to code for the primary procedure, 99491)

CPT® Code	Description
99426	Provided by clinical Staff supervised and directed by a physician or other qualified healthcare professional first 30 minutes of clinical staff time per calendar month
99427	Provided by clinical Staff supervised and directed by a physician or other qualified healthcare professional first 30 minutes of clinical staff time per calendar month, each additional 30 minutes of clinical staff time per calendar month (List separately in addition to code for the primary procedure, 99426)
99424	Provided personally by a physician or other qualified health care professional first 30 minutes per calendar month
99425	Provided personally by a physician or other qualified health care professional, each additional 30 minutes per calendar month (List separately in addition to code for the primary procedure, 99425)
G0442	Annual alcohol misuse screening, 5 to 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes, individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes, 2-4 patients
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes, 5-8 patients
T1017	Targeted case management, each 15 minutes
96372	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)
J0739	Injection, cabotegravir, 1 mg
87389	**Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method, e.g., HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result**
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method HIV-2
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique
G0435	Infectious agent antibody detection by rapid antibody test.
G0475	HIV antigen/antibody, combination assay, screening

CPT® Code	Description
82575	Creatinine, clearance
82565	**Creatinine, blood**
82570	Creatinine, other source
86592	Syphilis test, non-treponemal antibody, qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody, quantitative
86780	**Treponema pallidum**
87590	Neisseria gonorrhoeae, direct probe technique
87591	**Neisseria gonorrhoeae, amplified probe technique**
87592	Neisseria gonorrhoeae, quantification
87850	Infectious agent antigen detection by immunoassay with direct optical observation, Neisseria gonorrhoeae
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 immunofluorescent technique chlamydia trachomatis
87490	Chlamydia trachomatis, direct probe technique
87491	**Chlamydia trachomatis, amplified probe technique**
87810	Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis
80061	Lipid panel must include the following: cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)
86704	Hepatitis B core antibody (HBcAb), total
86705	Hepatitis B core antibody (HBcAb), IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
87340	**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, hepatitis B surface antigen (HBsAg)**

CPT® Code	Description
87341	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; hepatitis B surface antigen (HBsAg) neutralization
87467	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, hepatitis B surface antigen (HBsAg), quantitative
86803	**Hepatitis C antibody**
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot)
G0472	Hepatitis C antibody screening, for individuals at high risk and other covered indication(s)
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG), quantitative
84703	Gonadotropin, chorionic (hCG), qualitative
84450	Transferase, aspartate amino (AST) (SGOT)
84460	Transferase, alanine amino (ALT) (SGPT)
G0499	Hepatitis B screening in non-pregnant, persons at high risk- includes hepatitis B surface antigen (HBsAg), antibodies to HBsAg (anti-HBs) and antibodies to hepatitis b core antigen (anti-HBc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive HBsAG result
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique
87806	Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation, HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies
86689	HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	Antibody, HIV-1
86702	Antibody, HIV-2
86703	Antibody, HIV-1 and HIV-2, single result
	(For HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result, use 87389)
87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics
87903	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1, first through 10 drugs tested
87904	Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1, each additional drug tested (List separately in addition to code for primary procedure)

CPT® Code	Description
87534	Infectious agent detection by nucleic acid (DNA or RNA), HIV-1, direct probe technique
87535	Infectious agent detection by nucleic acid (DNA or RNA), HIV-1, amplified probe technique, includes reverse transcription when performed
87536	Infectious agent detection by nucleic acid (DNA or RNA), HIV-1, quantification, includes reverse transcription when performed
87357	Infectious agent detection by nucleic acid (DNA or RNA), HIV-2, direct probe technique
87538	Infectious agent detection by nucleic acid (DNA or RNA), HIV-2, amplified probe technique, includes reverse transcription when performed
87539	Infectious agent detection by nucleic acid (DNA or RNA), HIV-2, quantification, includes reverse transcription when performed
80081	Obstetric panel (includes HIV testing): This panel must include the following: • Blood count, complete (CBC), and automated differential white blood count (85025 or 85027 and 85004) OR • Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) • Hepatitis B surface antigen (HBsAg) (87340) • HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) • Antibody, rubella (86762) • Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) • Antibody screen, RBC, each serum technique (86850) • Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)
80055	Obstetric panel: This panel must include the following: • Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR • Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) • Hepatitis B surface antigen (HBsAg) (87340) • Antibody, rubella (86762) • Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) (86592) • Antibody screen, RBC, each serum technique (86850) • Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)

ICD-10 Codes

CPT® Code	Description
There are no codes to identify intravenous drug use. Report the following F codes only when the psychoactive substance use is associated with a disorder, and such a relationship is documented by the provider.	
F11.10	Opioid abuse, uncomplicated
F11.11	Opioid abuse, in remission
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence in remission
F11.90	Opioid use, uncomplicated
PrEP and PEP Related codes	
Z29.81	Use Z29.81 as primary ICD-10 code for all PrEP related services Encounter for HIV pre-exposure prophylaxis
Z51.81	Encounter for therapeutic drug level monitoring
Z01.812	Encounter for preprocedural laboratory examination
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for HIV
Z11.59	Encounter for screening for other viral diseases
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.5	Contact with and (suspected) exposure to viral hepatitis
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
Z20.828	Contact with and exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
The following codes are included for completeness only. The codes above are typically sufficient and avoid the use of the Z72.x codes that are considered stigmatizing because they indicate “problems related to lifestyle.” However, some payers may require these codes for reimbursement.	
Z72.51	High-risk heterosexual behavior
Z72.52	High-risk homosexual behavior
Z72.53	High-risk bisexual behavior

Z72.89	Other problems related to lifestyle
Z79.899	Other long term drug therapy
Z86.59	Personal history of other mental and behavioral disorders
Z87.898	Personal history of other specified conditions
Pregnancy related & Pregnancy Testing codes	
Z32.00	Encounter for pregnancy test result unknown
Z32.01	Encounter for pregnancy test result positive
Z32.02	Encounter for pregnancy test result negative
Report appropriate pregnancy code subsequent to any ICD-10 codes that are reported as the primary reason(s) for the visits or service.	
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 normal other pregnancy, unspecified trimester
Z34.81	Encounter for supervision of normal other pregnancy, first trimester
Z34.82	Encounter for supervision of normal other pregnancy, second trimester
Z34.83	Encounter for supervision of normal other pregnancy, third trimester
Z34.90	Encounter for supervision of normal unspecified pregnancy, unspecified trimester
Z34.91	Encounter for supervision of normal unspecified pregnancy, first trimester
Z34.92	Encounter for supervision of normal unspecified pregnancy, second trimester
Z34.93	Encounter for supervision of normal unspecified 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

Relative Value Units

As discussed in the Codes and Coding for Service section, a physician work relative value unit (WRVU) is assigned to most professional codes. The professional codes referenced in this guide and the associated WRVUs are listed below. As discussed previously, WRVUs do not translate directly to a reimbursement amount, they do allow the provider a sense of the relative value of one code to another. RVUs do not apply to laboratory services, equipment, or supplies.

CPT® Code	Work RVU	CPT® Code	Work RVU	CPT® Code	Work RVU
96372	0.17	99384	2.00	99423	0.80
98970	0.25	99385	1.92	99424	1.45
98971	0.44	99386	2.33	99425	1.00
98972	0.69	99387	2.50	99426	1.00
99202	0.93	99394	1.70	99427	0.71
99203	1.60	99395	1.75	99437	1.00
99204	2.60	99396	1.90	99439	0.70
99205	3.50	99397	2.00	99441	0.70
99212	0.70	99401	0.49	99442	1.30
99213	1.30	99402	0.98	99443	1.92
99214	1.92	99403	1.46	99490	1.00
99215	2.80	99404	1.95	99491	1.50
99282	0.93	99411	0.15	G0442	0.18
99283	1.60	99412	0.25	G0443	0.45
99284	2.74	99421	0.25	G2012	0.25
99285	4.00	99422	0.50		

Modifiers

Modifier	Description	Usage Notes
25	Significant, separately identifiable evaluation and management (E&M) service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.	Append Modifier 25 when an E&M service is performed that is distinct and separate from another service performed on that day. The other service may be a minor procedure, an annual wellness physical, or preventive counseling. Documentation of each service must be clear, distinct, and separately identifiable in the record. No overlap of elements or time is permitted. If two codes are chosen based on time, then the time for each service must be documented separately. Modifier 25 is appended to the visit code (E&M).
33	Preventive Services	Append Modifier 33 to services for which the primary purpose of the services is the delivery of an evidenced-based service in accordance with a USPSTF A or B or other mandated preventive services. This is particularly helpful for laboratory testing for which the codes are described as diagnostic but the provider is utilizing them in a preventive mode. If the service reported is specifically identified as preventive, do not append Modifier 33.
59	Distinct Procedural Service	At times it may be necessary to indicate that a procedure or test is distinct from other procedures or tests for the same patient on the same day by the same provider. For the purposes of PrEP testing, this modifier may be used at the payer's discretion when the test is performed on multiple sourced specimens. For example, a payer may require that tests from swabs obtained from three sources for testing chlamydia or gonorrhea be reported on three lines of a claim. Append Modifier 59 to the second and subsequent claim lines to indicate separate specimens or sources.
QW	CLIA Waived Test[61]	Modifier QW must be appended to every lab test that is designated as a CLIA-waived test.
93[62]	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	This is a new Modifier effective in 2022 but included only in the 2023 CPT book. This modifier is used to identify that a service met all the key components of a service as if it were rendered face to face, but it was rendered via audio-only technology. There is very little payer guidance published at this time. This modifier should only be appended to approved telehealth service codes. Although CPT indicated certain codes as Telemedicine-eligible, each payer is permitted to approve additional codes for telehealth.

[61]CLIA Waived Tests require Modifier QW. CMS typically publishes new waived test transmittals four times per year. The latest list published in June 2023 effective 10/2/2023 can be found here https://www.cms.gov/files/document/r12089cp.pdf
See also Place of Service codes in the TelePrEP section of this guide.

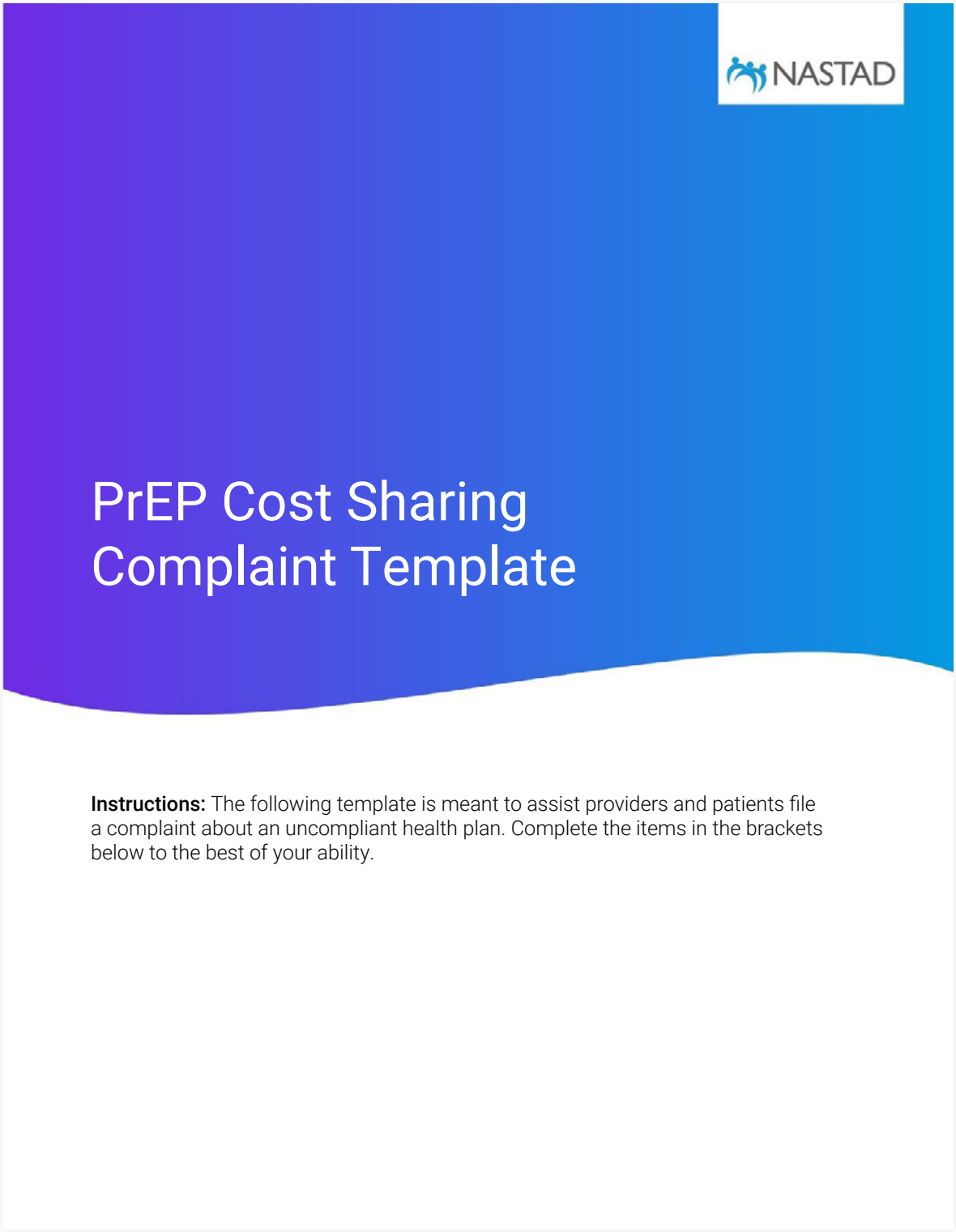
[62]Each year CMS publishes a list of codes that are eligible for reimbursement when performed as a telehealth service. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Append to telehealth-approved codes to identify that a service met all the key components of a service as if it were rendered face to face, but it was rendered via real-time audio and video technology. Payers publish specific code sets that are eligible for telehealth reimbursement.
92	Alternative Laboratory Platform Testing	Append modifier 92 to a lab test in the form of a kit or transportable instrument that consists of a single-use, disposable, analytical chamber. The service may be identified by adding modifier 92 to the usual laboratory procedure code.

NASTAD PrEP Cost Sharing Complaint Template

NASTAD Resource

The PrEP Cost Sharing Complaint Template is meant to assist providers and patients file a complaint about a non-compliant health plan charging for PrEP services. Download the Microsoft Word template and complete the items in the brackets to the best of your ability.[64]



[DATE]

NOTE: The bulleted list below provides information on how to find the applicable regulator's contact information. Remove the other regulator contacts before sending the final letter.

[REGULATOR]

STATE DEPARTMENT OF INSURANCE

- Regulates: individual market (on and off Marketplace), small group fully insured market, large group fully insured market
- Contact information available through NAIC consumer resources (scroll to find contact information for your state)

DEPARTMENT OF LABOR (DOL)

- Regulates: Self-funded employer plans
- Employee Benefits Security Administration complaint portal
- *NOTE: it may be advisable to first send your complaint to your employer's Human Resources department before elevating to DOL*

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

- Regulates: Self-funded non-federal government plan
- Email: NonFed@cms.hhs.gov
- *NOTE: it may be advisable to first send your complaint to your employer's Human Resources department before elevating to CMS*

Re: PrEP coverage for [BENEFICIARY NAME]

To Whom It May Concern:

I am an enrollee of [NAME OF PLAN] through my [NAME OF EMPLOYER OR IF INDIVIDUAL MARKET REFERENCE IF IT WAS PURCHASED ON MARKETPLACE OR OFF MARKETPLACE]. For the current plan year [REFERENCE PLAN YEAR) the plan ID is: [PLAN ID]. I am writing to appeal and request review of the plan's decision and overall policy to charge for cost sharing associated with pre-exposure prophylaxis (PrEP), a covered preventive service. This practice violates the Affordable Care Act

(ACA) preventive services coverage and cost-sharing protections.

My plan is a [FILL IN PLAN TYPE]

- Qualified Health Plan (QHP) sold in the [INDIVIDUAL OR SMALL GROUP] group [MARKETPLACE OR OFF-MARKETPLACE] market in [STATE]
- Self-funded non-federal government plan (e.g., a plan offered by a municipality)
- Self-funded employer plan
- Large group employer plan (fully insured)
- Small group employer plan (fully insured)

As such, it is subject to the ACA's Essential Health Benefits requirements, including the preventive services coverage and cost-sharing provisions codified at 42 USC §300gg–13 and 29 CFR § 2590.715-2713. Under these provisions, non-grandfathered group health plans are required to cover services with a Grade A or B from the U.S. Preventive Services Task Force (USPSTF) without cost sharing, starting no later than the plan year beginning one year after the final recommendation. In June of 2019, the USPSTF gave PrEP a final Grade A recommendation.[65] In July 2021, the Departments of Labor, Health and Human Services, and Treasury issued guidance for plans on implementation of the coverage and cost-sharing requirements.[66] The guidance clarifies that in addition to providing access to the PrEP medication without cost sharing, plans also must cover the following ancillary services without cost sharing:

HIV testing, including HIV-1 RNA testing (at initiation and every three months consistent with CDC guidelines[67])

- Hepatitis B and C testing (at initiation and periodically consistent with CDC guidelines)
- Creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR) (at initiation and periodically consistent with CDC guidelines)
- Sexually transmitted infection screening and counseling (at initiation and periodically consistent with CDC guidelines, including three-site anatomic testing gonorrhea and chlamydia and testing for syphilis, together with behavioral counseling)
- Adherence counseling (at initiation and regularly consistent with CDC guidelines)
- Office visits associated with each recommended preventive service when the primary purpose of the office visit is the delivery of the recommended preventive service.

[65]USPSTF, Final Recommendation Statement, Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (June 2019) available at https://www.uspreventiveservicestaskforce.org/home/getfilebytoken/poDYcagnw7SqKNNbrFt_CV.

[66]Departments of Labor, Health and Human Services, and the Treasury, FAQs about ACA Implementation Part 47 (July 19, 2021), available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf.

[67]US Public Health Service, Preexposure Prophylaxis for the Prevention of HIV Infection in the United States-2021 Update: A Clinical Practice Guidelines (December 2021) available at https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

Despite these clear requirements, I have been charged deductibles and/or cost sharing to access PrEP, including the following:

- [LIST ALL DATES OF SERVICES, THE PROVIDER WHO PROVIDED SERVICES AND WHETHER THAT PROVIDER WAS IN THE PLAN'S NETWORK, AND ALL COST SHARING CHARGED. YOU CAN GET THIS INFORMATION FROM LOOKING AT BOTH YOUR EXPLANATION OF BENEFITS FROM YOUR INSURER AND YOUR PROVIDER PORTAL WHICH WILL LIST THE SPECIFIC SERVICES AND LABS PROVIDED. BE AS SPECIFIC AS POSSIBLE].

According to federal law and according to the terms of my plan's coverage documents, I should not have been charged any cost sharing associated with PrEP, a USPSTF Grade A recommended service. I request that [PLAN NAME] immediately reimburse me for erroneous cost sharing already paid for PrEP and waive the remainder of cost sharing that [LAB AND/OR PROVIDER] has billed me. I also request that [PLAN NAME] swiftly adopt a coverage and cost-sharing policy for PrEP that is in line with federal law, regulation, and guidance, treating PrEP like it treats other ACA preventive services. This must include allowing beneficiaries to access these preventive services without cost sharing at point of service and without an arduous appeals process. Treating PrEP differently from other covered preventive services raises concerns of discriminatory plan design in violation of 42 U.S.C. § 18116 and 45 CFR § 146.121. Moreover, PrEP is a highly effective HIV prevention tool. The actions of [PLAN NAME], however, create arbitrary financial and administrative barriers to PrEP and will undoubtedly have negative individual and public health consequences.

Thank you for your prompt attention to this matter. I can be reached at [NUMBER AND EMAIL]

Sincerely,

Remittance Advice Codes

Remittance Advice codes are a nationally standardized code set that provides an explanation of any adjustment to the billed amount or the payment amount. These codes are maintained by CMS[68] and published by X12 an ANSI-accredited organization focusing on electronic data interchange standards. Although all of the code lists are essential in reading a remittance, there are three that are critical in deciphering the reasons for unexpected outcomes; claim adjustment group codes, claim adjustment reason codes, and remittance advice remark codes. These codes allow the user to determine the reason for any payment adjustment, a payment less than the billed amount. The group codes, the claim adjustment reason codes, and the remittance advice remark codes are used to communicate clearly why an amount is not covered by Medicare and who is financially responsible for that amount.
Like other code sets, these X12 codes are a national standard. Under HIPAA[69], a payer may use these in slightly different ways, but they cannot alter the codes or descriptions nor can they create any proprietary denial codes.

Claim Adjustment Group Codes

Code	Description
CO	Contractual Obligation
OA	Other Adjustment
PI	Payer Initiated Reduction
PR	Patient Responsibility

Claim Adjustment Group Codes identify the general category of the payment adjustment. These codes indicate which party is financially responsible for that amount.

Claim Adjustment Reason Codes (CARC)

Claim Adjustment Reason Codes describe why a claim or service line is paid differently than it was billed.

Sample of CARCs

1	Deductible Amount
2	Coinsurance Amount
4	The procedure code is inconsistent with the modifier used.
7	The procedure/revenue code is inconsistent with the patient's gender.

[68]The Medicare Claims Processing Manual Chapter 22 – Remittance Advice is a publication to be used as a companion when reading a Remittance Advice (RA), a.k.a. an Explanation of Benefits (EOB).

[69]The 1996 Health Insurance Portability and Accountability Act (HIPAA) required HHS and payers to adopt national standard code sets for electronic transactions. These code sets included CPT, ICD, HCPCS, NPI, ANSI X12, NDC, and ADA dental Codes.

Remittance Advice Remark Codes (RARC)

Remittance Advice Remark Codes are used on an EOB to further explain a claims adjustment reason code. They are used to relay additional information that cannot be conveyed by using a CARC alone. Additionally, remark codes may also be used to convey general information to the user.

Sample of RARCs

N640	Exceeds number/frequency approved/allowed within time period.
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
M90	Not covered more than once in a 12-month period.
M86	Service denied because payment was already made for same/similar procedure within set time frame.

Place of Service Code Set[70]

The following is a sample of outpatient POS codes. As with other code types, check with the payer to verify coverage.

Code	Name	Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters)
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

[70]The Place of Service Code Set listing is published and maintained by CMS https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set

14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other POS code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
27	Outreach Site/ Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered persons experiencing homelessness.
49	Independent Clinic	A location, not part of a hospital and not described by any other POS code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

Payer Guidance

Payer guidance can be presented in a number of forms. Payers may issue medical policies, NCDs, LCDs (local coverage determinations), provider guidance, or even fee schedules. All of these publications have information critical to submitting payable claims. Many of the publications will also link to related guidance for that payer as well. These publications are updated fairly frequently. Determine the top payers by volume for your organization, find the payer guidance related to PrEP and PEP, and verify that your organization is using the most up to date document. Typically, PrEP payer guidance has been found within the broader preventive services policy. Once that broader publication is found, search the document for PrEP or PrEP related terms.

Payer websites do not always have robust internal search engines which can make the search for specific guidance indirect and not always successful. Using specific terms and payer names in a general internet search may be more effective. Using your preferred search engine, use search terms that include

- Payer name or acronym (BCBSNC or Blue Cross Blue Shield of North Carolina, UHC or United HealthCare)
- Preventive care services
- Health Care Reform Preventive Services Coding Guide
- When you find guidance that has what you need, use the words in that document to find others.

Using the term PrEP is not always the most effective search as the case of the letters in the search are not used and the search will return many documents with the word preparation or preparing or prepay. However, use the search term PrEP within the preventive services document to find the resource needed.

Payer guidance examples

UNITED HEALTHCARE

Preventive Care Services is a comprehensive United Healthcare (UHC) preventive services document that includes PrEP coding guidance. Within it, there are links to UHC policy for long-acting injectable antiretroviral agents for HIV, behavioral counseling to prevent STIs, Preventive Medicine and Screening Policy, and a Telehealth-Eligible-Services-Code-List

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/preventive-care-services.pdf

CIGNA

Preventive Care Services is a comprehensive CIGNA preventive services document with CPT® and ICD-10 codes.

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/ad_a004_administrativepolicy_preventive_care_services.pdf

BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

Health Care Reform Preventive Services Coding Guide contains very specific ICD-10 and CPT® requirements for billing preventive services.

https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/bcbsnc_hcr_preventive_services.pdf

Medi-Cal (California Medicaid) contains very specific CPT® and ICD-10 guidance for PrEP and other USPSTF Grade A and B services.

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/DDBB7BD0-9D06-4B3C-9597-7FAFF5471E6F/prev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO