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Internal Medicine Coding Alert

Follow 4 Steps to Win Approval for Expanded HIV Screens

Make sure to get your diagnosis codes right -- here's the rundown.

Retroactive to Dec. 8, 2009, you now have the opportunity to diagnosis more HIV positive beneficiaries in the earliest stage of the disease.

CMS announced the HIV screening coverage extension in its Feb. 19 national coverage determination (NCD, Pub. 100-03), and created three new "G" codes to implement the coverage.

Read on for your need-to-know briefing, including which diagnoses payers will recognize and how to report this service for encounters starting with Dec. 8, 2009.

1: Reference 3 New 'G' Codes

To report HIV screenings for certain beneficiaries, turn to one of the followingnew codes:

• G0432 -- Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening

• G0433 -- Infectious agent antigen detection by enzyme-linked immunosorbentassay (ELISA) technique, antibody, HIV-1 or HIV-2, screening

• G0435 -- Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.

"It looks like this change is primarily authorizing rapid tests" for individuals at "increased risk" of contracting HIV, comments **Jean S. Oglevee, LPN, CPC,** director of coding, compliance and clinical services at Family Medicine Clifton/Centreville in Virginia.

Early warning: "The HIV antigen can be detected early in the course of HIV,before the appearance of antibodies," notes **Jill Young, CPC, CEDC, CIMC,** with Young Medical Consulting LLC in East Lansing, Mich. "This test has a specific 'early window' -- some resources say 16 days [after exposure]."

G code fact: Medicare typically creates G codes for tracking purposes so it "can determine volume, medical necessity, and if a permanent HCPCS code is warranted," explains **Terry Fletcher, BS, CPC, CCS-P, CCS, CMSCS, CCC, CEMC, CMC,** healthcare coding consultant and CEO/President of Terry Fletcher Consulting, Inc. in Laguna Beach, Calif.

Look for: The Medicare Learning Network Matters article on the HIV screening NCD, which Medicare should release shortly, will presumably help physicians and coders determine which of the three tests is appropriate for which scenario, says Fletcher.

2: Verify Coverage by Risk, Pregnancy

CMS will cover the above HIV screens for two specific types of beneficiaries:

• those it deems at "increased risk" (see shaded insert for risk details).

• pregnant women.

Frequency: Beneficiaries at increased risk may receive "**one** annual voluntary HIV screening." Eleven full months must elapse following the month in which the patient received the previous test in order for the subsequent test to be covered, states the NCD. Pregnant women, however, may receive **three**, voluntary HIV screenings for each term of pregnancy:

1. when the diagnosis of pregnancy is known

2. during the third trimester

3. at labor.

Remember: Deductibles and coinsurance do not apply to HIV screenings.

3: Chose From Only 5 ICD-9 Codes

For beneficiaries reporting increased risk factors, use two diagnosis codes on the claim:

• V73.89 -- Special screening for other specified viral disease as primary, **and**

• V69.8 -- Other problems related to lifestyle as the secondary diagnosis.

For beneficiaries who do not disclose specific increased risk factors, report diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, report V73.89 as primary, and one of the following as secondary (to allow for more frequent screening than the once per 12-month period allows):

• V22.0 -- Supervision of normal first pregnancy

• V22.1 -- Supervision of other normal pregnancy

• V23.9 -- Supervision of unspecified high-risk pregnancy

Tip: If you receive a denial when submitting this claim, you have likely submitted an incorrect code, warns the CMS transmittal. "MSN 16.10 Medicare does not pay for this item or service" means that you have used the wrong G code (other than G0432, G0433, or G0435). "CARC 167-This (these) diagnosis(es) is (are) not covered" means that you are have submitted an incompatible ICD-9 code (other than V73.89, or V73.89 and V69.8, or one of the pregnancy codes listed above).

4: Stick with the 'Unlisted' Code, For Now

Don't plan on using the new G codes straight away. The Medicare release advises using an unlisted code (87999, Unlisted microbiology procedure) for newly covered HIV screens performed on or after Dec. 8, 2009 and reported before April 5, 2010.

Attach documentation to the claim explaining why you are using 87999, notes Young. When the payer sees you are reporting the screening test, it will pay the price it has determined. When the new G codes take effect, payers will likely continue to price the G codes in the same way.

Downside: When Medicare or CPT "suggest" an unlisted code, this is not a guarantee of payment, warns Fletcher. Rather, the unlisted code gives "the provider an option to capture the service and hope for reimbursement."

Between April 4, 2010, and Jan. 1, 2011, the G codes will be contractor priced, notes the transmittal. "When I read this, I was disappointed that CMS issued the directive that, prior to these codes being added to the CLFS (Clinical Lab Fee Schedule), they will be contractor priced," laments Fletcher.

"That means it will be up to the MAC (Medicare Administrative Contractor) to determine reimbursement -- I do not see [some carriers] jumping on this," Fletcher comments.

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Resource: Find the full details at www.cms.hhs.gov/transmittals/downloads/R1935CP.pdf