CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1935	Date: March 23, 2010
	Change Request 6786

Transmittal 1918, dated February 19, 2010, is rescinded and replaced with Transmittal 1935, dated March 23, 2010. The changes are: (1) changed the NOS code from 99199 to 87999, (2) checked carrier for Business Requirements (BRs) 6786.4 and 6786.4.1, (3) deleted reference to CWF edits for V69.8 in BR 6786.7, and (4) added a note in BR 6786.7.1 to make CWF edits overridable. All other information remains the same.

SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

I. SUMMARY OF CHANGES: Effective January 1, 2009, CMS is authorized to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act. One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the US Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women. Effective for claims with dates of service on and after December 8, 2009, CMS supports the USPTFS recommendations with the posting of its final decision in this regard.

EFFECTIVE DATE: DECEMBER 8, 2009
IMPLEMENTATION DATE: JULY 6, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/Table of Contents
N	18/130/Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests
N	18/130.1/ Billing Requirements
N	18/130.2/Payment Method
N	18/130.3/Types of Bill (TOBs) and Revenue Codes
N	18/130.4/Diagnosis Code Reporting
N	18/130.5/Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARC)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs): The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1935	Date: March 23, 2010	Change Request: 6786

Transmittal 1918, dated February 19, 2010, is rescinded and replaced with Transmittal 1935, dated March 23, 2010. The changes are: (1) changed the NOS code from 99199 to 87999, (2) checked carrier for Business Requirements (BRs) 6786.4 and 6786.4.1, (3) deleted reference to CWF edits for V69.8 in BR 6786.7, and (4) added a note in BR 6786.7.1 to make CWF edits overridable. All other information remains the same.

SUBJECT: Screening for the Human Immunodeficiency Virus (HIV) Infection

EFFECTIVE DATE: DECEMBER 8, 2009

IMPLEMENTATION DATE: JULY 6, 2010

I. GENERAL INFORMATION

A. Background: Effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is authorized to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act. One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the US Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

B. Policy: Effective for claims with dates of service on and after December 8, 2009, CMS determines that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Therefore CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

1. One, annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with Pub. 100-03, National Coverage Determinations Manual (NCD), sections 190.14 and 210.7, and Pub. 100-04, Medicare Claims Processing Manual (CPM), chapter 18, section 130.

NOTE: Eleven full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

2. Three, voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's physician, and in accordance with Pub. 100-03 and Pub. 100-04, as noted above.

NOTE: Three tests will be covered for each term of pregnancy beginning with the date of the 1st test.

NOTE: The USPSTF guidelines upon which this policy is based contains 8 increased-risk criteria. The first 7 require the presence of both ICD-9 diagnosis codes V73.89 and V69.8 for the claim to be paid. The last

criterion, which covers persons reporting no increased risk factors, only requires ICD-9 V73.89 for the claim to be paid.

NOTE: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

NOTE: The following three new HCPCS codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 IOCE and January 2011 clinical lab fee schedule (CLFS) updates:

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

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

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

NOTE: Prior to inclusion of the above G codes on the CLFS, the above G codes shall be contractor-priced. For dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

II. BUSINESS REQUIREMENTS TABLE
Use"Shall" to denote a mandatory requirement

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6786.1	Effective for claims with dates of service on and after December 8, 2009, contractors shall pay claims for HIV screening tests for Medicare beneficiaries subject to criteria in Pub. 100-03, NCD, sections 190.14 and 210.7, and Pub. 100-04, CPM, chapter 18, section 130.	X		X	X						
6786.2	Contractors shall pay claims for HIV screening test annually for male and female Medicare beneficiaries containing HCPCS codes G0432, G0433, or G0435, along with ICD-9 diagnosis codes V73.89 (special screening for other specified viral disease) as primary, when no increased risk factors are reported.	X		X	X		X				4/2010 IOCE 1/2011 CLFS
6786.2.1	Contractors shall pay claims for HIV screening test annually for male and female Medicare beneficiaries containing HCPCS codes G0432, G0433, or G0435, along with ICD-9 diagnosis codes V73.89 as primary, and V69.8 (other problems related to lifestyle), as secondary, when increased risk factors are reported.	X		X	X		X				
6786.3	Contactors shall pay claims for pregnant female	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Medicare beneficiaries containing HCPCS codes G0432, G0433, or G0435 with ICD-9 diagnosis codes V73.89, along with one of the following ICD-9 diagnosis codes as secondary: V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy).										
6786.4	Contractors shall pay claims for HIV screening tests containing HCPCS codes G0432, G0433, or G0435 on TOBs 12X, 13X, 14X, 22X, and 23X, under the clinical lab fee schedule. Deductible and coinsurance do not apply. **NOTE:** Prior to inclusion in the CLFS, the above G codes shall be contractor-priced. Between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used.	X		X	X						
6786.4.1	Contractors shall pay claims for HIV screening tests containing HCPCS codes G0432, G0433, or G0435 on TOB 85X under reasonable cost.	X		X	X						
6786.5	Contractors shall only allow HCPCS codes G0432, G0433, or G0435 with ICD-9 codes V73.89 , V69.8, and V22.0, V22.1, or V23.9 (for pregnant female Medicare beneficiaries), to be billed with revenue code 030X.	X		X							
6786.6	Contractors shall deny claims for HIV screening tests billed without HCPCS codes G0432, G0433, or G0435 and ICD-9 diagnosis codes V73.89, or V73.89 and V69.8 (when increased risk factors are reported) using the following messages: MSN 16.10 Medicare does not pay for this item or service. "Medicare no paga por este articulo o servicio" CARC 167- This (these) diagnosis(es) is (are) not covered. **NOTE:** If an advance beneficiary notice (ABN) is provided, use Group Code PR (Patient Responsibility). If an ABN is not provided, use Group Code CO (Contractual Obligation).	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6786.7	Effective for claims with dates of service on or after December 8, 2009, CWF shall create an edit to allow no more than 1 HIV screening test annually containing HCPCS codes G0432, G0433, or G0435 and ICD-9 code V73.89, with the exception in 7.1 below. Eleven full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.									X	
6786.7.1	Effective for claims with dates of service on or after December 8, 2009, CWF shall create an edit to allow no more than 3 HIV screening tests during each term of pregnancy beginning with the date of the 1st test containing HCPCS codes G0432, G0433, or G0435 and ICD-9 code V73.89 and accompanied by one of the diagnosis codes V22.0, V22.1, or V23.9. **NOTE:** CWF shall allow this edit to be overridable back to the contractor for an R&N determination.									X	
6786.7.2	Contractors shall deny claims due to the frequency limitations in BRs .7 and 7.1 above using the following messages: MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service. "La informacíón proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio." CARC 119 – Benefit maximum for this time period or occurrence has been reached. **NOTE:** If an ABN is provided, use Group Code PR. If an ABN is not provided, use Group Code CO.	X		X	X		X				
6786.8	Effective for claims with dates of service on and after December 8, 2009, CWF shall update Major Category IV for SNF CB to include HCPCS G0432, G0433, or G0435 in order to allow only 22X bill types to bypass SNF CB edits.									X	
6786.9	Effective for claims with dates of service on and after	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	December 8, 2009, contractors shall pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, TOBs 12X, 13X, or 14X, on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.										
6786.10	For claims with dates of service between December 8, 2009, and July 5, 2010, contractors shall not mass-adjust claims but shall adjust claims brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6786.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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Post-Implementation Contact(s): Appropriate regional office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev.1935, 03-23-10)

130 – Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests

(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

Effective for claims with dates of service on and after December 8, 2009, implemented with the April 5, 2010, IOCE, the following HCPCS codes are to be billed for HIV screening:

- *G0432- Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening,*
- *G0433 - Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening, and,*
- *G0435 - Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.*

130.1 – Billing Requirements

(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

Effective for dates of service December 8, 2009, and later, contractors shall recognize the above HCPCS codes for HIV screening.

Medicare contractors shall pay for voluntary HIV screening as follows in accordance with Pub. 100-03, Medicare National Coverage Determinations Manual, sections 190.14 and 210.7:

- *A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,*
- *A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.*

Claims that are submitted for HIV screening shall be submitted in the following manner:

For beneficiaries reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 (Special screening for other specified viral disease) as primary, and V69.8 (Other problems related to lifestyle), as secondary.

For beneficiaries not reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 as primary, and one of the following ICD-9 diagnosis codes: V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy), as secondary.

130.2 - Payment Method
(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

Payment for HIV screening is under the Medicare Clinical Laboratory Fee Schedule for TOBs 12X, 13X, 14X, 22X, and 23X beginning January 1, 2011. For TOB 85X payment is based on reasonable cost. Deductible and coinsurance do not apply. Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted procedure code 87999. Between April 5, 2010, and January 1, 2011, the G codes will be contractor priced.

130.3 - Types of Bill (TOBs) and Revenue Codes
(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

The applicable bill types for HIV screening are: 12X, 13X, 14X, 22X, 23X, and 85X. (Effective April 1, 2006, TOB 14X is for non-patient laboratory specimens.)

Use revenue code 030X (laboratory, clinical diagnostic).

130.4 – Diagnosis Code Reporting
(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims where increased risk factors are reported: V73.89 as primary and V69.8 as secondary.

b. For claims where increased risk factors are NOT reported: V73.89 as primary only.

c. For claims for pregnant Medicare beneficiaries, the following diagnosis codes shall be submitted in addition to V73.89 to allow for more frequent screening than once per 12-month period:

V22.0 – Supervision of normal first pregnancy, or,
V22.1 – Supervision of other normal pregnancy, or,
V23.9 - Supervision of unspecified high-risk pregnancy).

130.5 – Medicare Summary Notice (MSN) and Claim Adjustment Reason Codes (CARC)
(Rev. 1935, Issued: 03-23-10, Effective: 12-08-09, Implementation: 07-06-10)

a. When denying claims for HIV screening submitted without ICD-9 diagnosis codes V73.89, or V73.89 and V69.8, use the following messages:

MSN 16.10 - Medicare does not pay for this item or service.

"Medicare no paga por este articulo o servicio"

CARC 167- This (these) diagnosis(es) is (are) not covered.

Group Code CO (Contractual Obligation)

b. *When denying claims for HIV screening, use the following denial messages:*

MSN 15.22 – The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

"La información proporcionada no justifica la necesidad de esta cantidad de servicios o articulos en este periodo de tiempo por lo cual Medicare no pagará por este articulo o servicio."

CARC 119 – Benefit maximum for this time period or occurrence has been reached.

Group Code CO (Contractual obligation).