HIV Coding for Public Health Departments

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Presenter

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Shefali Mookencherry has extensive experience in the HIPAA, healthcare IT/finance, Meaningful Use, billing, coding, contracting, credentialing, and revenue cycle areas, including 20+ years in the healthcare industry, with nine spent in senior management positions.

She has conducted various billing, coding, contracting, credentialing, and HIPAA education, training, compliance assessments/analyses for various clients including public health departments/associations, small physician practices, IT vendors to larger integrated delivery networks and academic institutions.
Assumptions

- Certain information in this presentation comes from a variety of sources such as:
  - CMS (their website cms.gov)
  - American Health Information Management Association (AHIMA)
  - American Medical Association (AMA)
  - American Academy of Professional Coders (AAPC)
  - National Alliance of State and Territorial AIDS Directors (NASTAD)
  - Managed Care Payers
  - Industry blogs, journals, etc.

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Objectives

- Understand the HIV coding environment...Now.
- Review of documentation and coding for HIV services.
- Review of several HIV coding scenarios.
- Review of coding crosswalk from ICD-9 to ICD-10 for HIV services.
- Understand maintenance of HIV coding processes.
- Questions and Answers
HIV Coding Environment...Now.
**HIV Coding Environment....**

- Local health departments must use code sets when submitting claims for reimbursement. (HIPAA requirement)
- All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code and applicable CPT procedure code in order to be reimbursed.
A local health department could provide a service that is covered and described by a CPT® code, but not have the allowable (proper) diagnosis code that justifies reimbursement by the payer.

- In which case, the claim is rejected and the service will not be reimbursed.

Individual insurance companies and state Medicaid programs are free to develop a set of reimbursement and payment guidelines, and are not required to cover all services described by a CPT® code.
Delivery Models

- Local health department.
- Local health department partnering with community based organization(s) or individual physicians and other clinicians.
- Local health department partnering with laboratories.

Note: Some payers may categorize local health department clinics as “Rural health clinics”.
AIDS/HIV Services

- Screening/Evaluation
- Testing
- Diagnosis
- Monitoring
- Counseling
- Treatment
AIDS/HIV Providers

- Physician
- Nurse practitioner
- Physician assistant
- Peer counselors certified as Community Health Workers
- Community based organizations
- HIV laboratories
Documentation and Coding for HIV Services
The Health Record

- Centers for Medicare and Medicaid Services (CMS), health record documentation requirements include:
  - Pertinent facts
  - Findings
  - Observations about an individual’s health history including:
    - Past and present illnesses
    - Examinations/tests
    - Treatment
    - Outcomes
- Document every step you take.
Documentation...

- When – document on the day service provided.
- What – document the services provided to the patient.
- Where – Medical Record (SOAP Format, Standard Form, Progress Notes, Problem List, Medication Page, etc.).
- How – Hard (blue or black ink) or EMR. Provider name and credentials MUST be noted!
- Who – All staff who provided a service.
- Why – patient safety, agency safety, provider safety, for billing purposes, research and for quality improvement purposes.
- Authority - Laws requiring medical records and documentation of clinical services.
HIV Testing Documentation

- First visit may include:
  - The signed HIV consent form (varies by state/jurisdiction)
  - HIV test results
  - Notation that the test results were communicated to the patient

- Second visit may include:
  - Written justification for the rationale for the second or subsequent HIV test visit (i.e. risks identified during the first visit requiring further counseling)
HIV Pre-Test Counseling Without Testing Documentation

- Written documentation should clearly state counseling was provided
- The reason why the patient declined testing
- The follow up care plan, including indications for further counseling and testing
Billable Service Types Could Be...

- Evaluation and Management Services
- Risk assessment counseling
- Information / pamphlets
- HIV counseling and testing
- Linkage to Care & Patient Navigation/ Care Coordination/ Case Management
- Screening and treatment for:
  - HIV/AIDS
Non-billable Service Types

- Case management codes are not recognized by Medicare but other insurers may cover them, so it is important to check with the individual insurers.
  - Ryan White Funded Support Service
HIV Billing Codes

- CPT
  - E/M
  - Procedure
- Modifiers
- ICD-10-CM (effective October 1, 2015)
- HCPCS
### HIV Testing Codes Example

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>CPT codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>B20</td>
<td>Human immunodeficiency virus [HIV] disease</td>
</tr>
</tbody>
</table>

#### HIV Testing and Counseling Visit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>99401</td>
</tr>
<tr>
<td>Expanded</td>
<td>99402</td>
</tr>
<tr>
<td>Detailed</td>
<td>99403</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>99404</td>
</tr>
</tbody>
</table>

#### Laboratory

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HV 1 &amp; 2 rapid test</td>
<td>86703-92</td>
</tr>
</tbody>
</table>
Key ICD-10 Coding Steps

- Step 1: Find the condition in the alphabetic index.
- Step 2: Verify the code and identify the highest specificity.
- Step 3: Review the chapter-specific coding guidelines.
ICD-10-CM Guidelines

- Located specifically in section I.C.1 under Chapter 1, Certain Infectious and Parasitic Diseases (I.C.1.a.1 – I.C.1.a.2.h).
- Code only confirmed cases of HIV infection/illness (I.C.1.a.1).
  - Confirmation does not require documentation of positive serology or culture for HIV, but that the provider's diagnostic statement that the patient is HIV positive or has an HIV-related condition.
- If client is HIV positive and asymptomatic, do not code from Chapter 1.
ICD-10-CM Codes for HIV

- The codes assigned for HIV may include:
  - B20 Human immunodeficiency virus (HIV) disease
  - Z21 Asymptomatic human immunodeficiency virus (HIV) infection status
  - Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus (HIV)
  - Z71.7 Human immunodeficiency virus (HIV) counseling
  - Z11.4 Encounter for screening for human immunodeficiency virus (HIV)
  - R75 Inconclusive laboratory evidence of human immunodeficiency virus (HIV)
ICD-10-CM Code B20...

- B20 is a specific ICD-10-CM code that can be used to specify the diagnosis:
  - Human immunodeficiency virus [HIV] disease
- Reimbursement claims with a date of service on or after October 1, 2015 require the use of ICD-10-CM codes.
- This is the American ICD-10-CM version of B20. Other international ICD-10 versions may differ.
ICD-10-CM Code B20...

- Grouped within Diagnostic Related Group(s) (MS-DRG v32.0):
  - **969** HIV with extensive o.r. procedure with mcc
  - **970** HIV with extensive o.r. procedure without mcc
  - **974** HIV with major related condition with mcc
  - **975** HIV with major related condition with cc
  - **976** HIV with major related condition without cc/mcc
  - **977** HIV with or without other related condition
HIV Coding Scenarios
ICD-10-CM HIV Coding Example

- An HIV patient presented to the clinic with what he thought was bruising. A biopsy was performed and a diagnosis of Kaposi's sarcoma of the skin is confirmed.
  - B20 Human immunodeficiency virus (HIV) disease
  - C46.0 Kaposi's sarcoma of skin
  - There is an instructional note under category C46, Kaposi's sarcoma, which reinforces the guideline by stating to code first any human immunodeficiency virus (HIV) disease (B20).
ICD-10-CM HIV Coding Example

- If a patient is admitted for an unrelated condition, the code for the unrelated condition should be the first-listed diagnosis. See example below:
  - A patient presents for a check up for his acute diastolic congestive heart failure. She also has HIV.
    - I50.31 Acute diastolic (congestive) heart failure
    - B20 Human immunodeficiency virus (HIV) disease
- In this case, the patient is being seen for her CHF, which is not related to her HIV, so the CHF is coded first, followed by the code for HIV (B20).
ICD-10-CM HIV Coding Example

- If a patient is being seen to determine his/her HIV status:
  - Z11.4, Encounter for screening for human immunodeficiency virus [HIV].
  - Use additional codes for any associated high risk behavior.

- If a patient with signs or symptoms is being seen for HIV testing:
  - Code the signs and symptoms.
  - An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, if applicable.
ICD-10-CM HIV Coding Example

- What happens if a patient has been tested for HIV and is coming in for test results and they are negative?
  - When a patient returns to be informed of his/her test results and the test result is negative:
    - Z71.7, Human immunodeficiency virus (HIV) counseling
ICD-10-CM HIV Coding Example

- Patient/Client returns today to be screened once again for HIV. The laboratory evidence for the HIV test conducted 2 weeks ago was inconclusive. HIV counseling was provided during the previous visit but client has questions that required additional counseling during today’s visit.
  - Z11.4 (Screening, human...)
  - R75 (human, immunodeficiency, laboratory evidence)
  - Z71.7 (Counseling, human....)
ICD-10-CM HIV Coding Tips

- Do not use the code for HIV (B20) or HIV+ (Z21) when the record/chart states:
  - Suspected
  - Suspicion of
  - Possible
  - Likely
  - Rule out
  - Questionable
  - Consistent with
  - Presumed to be
  - Appears
ICD-10-CM HIV Coding Tips

- Codes designated as principal diagnosis codes are always sequenced first.
- Codes designated as secondary/subsequent diagnoses codes are never sequenced first.
- Opportunistic infection codes are always assigned as the secondary diagnoses if supported by medical record documentation.
CPT Codes for HIV Services

- 99201–99205 for “new” patients
- 99211–99215 for “established” patients.
- Patient services performed by a staff member “incident” to a licensed clinician and supervised by the clinician:

| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. |
Nurse Visits

- 99211 may be billed for certain services provided by a Nurse.
- Not all payers recognize this service.
- Patient must be established.
- Provider-patient encounter must be face-to-face.
- An E/M service must be provided.
  - Generally, this means that the patient’s history is reviewed, a limited physical assessment is performed or some degree of decision making occurs.
Nurse Visits

- Since 99211 is an E/M code, there are some minimal documentation requirements in order to meet medical necessity for use of the code
  - There must be a face to face encounter
  - Nature of the presenting problem with a diagnosis from prior visit with a clinician
  - Brief history of the problem
  - Documentation of vital signs (sole reason for visit should not be Blood Pressure check or Blood Draw)
  - Plan of care
  - Date/signature of the nurse or other provider
Services Not Billed Under 99211

- Administering routine medications by physician or staff whether or not an injection or infusion code is submitted separately on the claim
- Checking blood pressure when the information obtained does not lead to management of a condition or illness
- Drawing blood for laboratory analysis or for a complete blood count panel, or when performing other diagnostic tests whether or not a claim for the venipuncture or other diagnostic study test is submitted separately
- Faxing medical records
Services Not Billed Under 99211

- Making telephone calls to patients to report lab results and reschedule patient procedures
- Performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed, or payment is bundled with reimbursement for another service) whether or not the procedure code is submitted on the claim separately
- Recording lab results in medical records
- Reporting vaccines
- Writing prescriptions (new or refill) when no other evaluation and management is needed or performed
Preventive CPT Codes

- Preventive medicine codes used in the absence of an established diagnosis.
  - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
    - 99401 approximately 15 minutes
    - 99402 approximately 30 minutes
    - 99403 approximately 45 minutes
    - 99404 approximately 60 minutes
HIV Screening CPT Codes

- Antibody
  - 86701 HIV-1
  - 86702 HIV-2
  - 86703 HIV-1 and HIV-2, single result
    - (For HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result, use 87389)
    - (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)
For Medicare Patients Use...

**HCPCS Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening</td>
</tr>
<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening</td>
</tr>
</tbody>
</table>
HIV Screening CPT Modifiers

- **Modifier 33**
  - Informs the payer that the service is a service recommended by the USPSTF.

- **Modifier 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, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389).
Modifier QW—CLIA Waived Test

- Laboratory provider must have:
  - Certificate of Compliance
  - Certificate of Accreditation or Certificate of Registration in order to perform clinical diagnostic laboratory procedures of high or moderate complexity.

- Waived tests include test systems cleared by the FDA designated as simple; have a low risk for error; and are approved for waiver under the CLIA criteria.
  - Only report with Path/Lab test codes (86701-86703, G0433G0435)
  - Do NOT report on any other code type
  - If a combination of waived and non-waived tests are performed, modifier QW should not be used
  - Contact your local Medicaid agency for specific guidance
Codes for Laboratory Services

- Bill laboratory codes for laboratory tests done on site.
  - CPT Code 36415 = one venipuncture collection fee when the lab work is sent out to an outside lab regardless of the number of specimens drawn.
  - HIV Blood Draw
  - CPT Code 99000 = handling, transfer and/or conveyance of specimen from LHD to another laboratory.
ICD-9 to ICD-10 Crosswalk for HIV Services
<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>Direct/Approx.</th>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V01.79</td>
<td>Contact with or exposure to venereal diseases</td>
<td>Approx.</td>
<td>Z20.6</td>
<td>Contact with and (suspected) exposure to human immunodeficiency virus (HIV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z20.828</td>
<td>Contact with and (suspected) exposure to other viral communicable diseases</td>
</tr>
<tr>
<td>V65.44</td>
<td>Human immunodeficiency virus (HIV) counseling</td>
<td>Direct</td>
<td>Z71.7</td>
<td>Human immunodeficiency virus (HIV) counseling</td>
</tr>
<tr>
<td>V70.0</td>
<td>Routine general medical examination at a health care facility</td>
<td>Approx.</td>
<td>Z00.00</td>
<td>Encounter for general adult medical examination without abnormal findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z00.01</td>
<td>Encounter for general adult medical examination abnormal findings*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Use additional code to identify abnormal findings (R70-R94)</td>
</tr>
</tbody>
</table>
# ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>Direct/ Approx.</th>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V73.89</td>
<td>Special screening examination for other specified viral diseases (e.g. HIV, HSV)</td>
<td>Approx.</td>
<td>Z11.4</td>
<td>Encounter for screening for human immunodeficiency virus (HIV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Z11.59</td>
<td>Encounter for screening for other viral diseases</td>
</tr>
<tr>
<td>042</td>
<td>HIV disease</td>
<td>Direct</td>
<td>B20</td>
<td>HIV disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable (098.7-)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>**Use additional code(s) to identify all manifestations of HIV infection</td>
</tr>
</tbody>
</table>
## ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>Direct/Approx.</th>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>079.53</td>
<td>HIV, type 2 (HIV-2)</td>
<td>Direct</td>
<td>B97.35</td>
<td>HIV, type 2 (HIV-2) as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td></td>
<td>* Report as secondary diagnosis code only</td>
<td></td>
<td></td>
<td>Note: Provided for use as supplementary or additional code to identify the infectious agent(s) in diseases classified elsewhere</td>
</tr>
<tr>
<td>V08</td>
<td>Asymptomatic HIV infection status</td>
<td>Direct</td>
<td>Z21</td>
<td>Asymptomatic HIV infection status. * Code first HIV disease complicating pregnancy, childbirth and the puerperium, if applicable (098.7-)</td>
</tr>
</tbody>
</table>
Maintenance of HIV Coding Processes
Coding Maintenance

- Local health departments/clinics could improve their coding processes by:
  - Updating code sets based on given regulatory schedule
  - Reviewing local coverage determinations (LCD) and national coverage determinations (NCD) by payer
  - Collaborating with physicians and other clinicians on documentation accuracy
  - Working with vendors
  - Working with payers to review contractual coding changes or updates
  - Analyzing revenue risks
  - Performing claim reviews
  - Conducting coding compliance audits
HIV Screening Denials

- A screening test may be denied because:
  - 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.
  - The patient is already diagnosed with the condition, and no longer needs to be screened for the illness.
  - An incorrect diagnosis is reported.
  - The payer has established frequency limits for the service.
  - Modifier 33 was not appended to the CPT® or HCPCS code.
Summary

- Proper HIV documentation and coding could support compliant HIV billing practices.
- Make HIV coding more efficient.
  - Develop a list of your most commonly used ICD-10 codes, CPT codes, G codes, and modifiers by payer.
  - Invest in an inexpensive software program that helps with coding. (if applicable)
  - Review ways to make sure new coding processes do not delay payments.
    - Look at your most common non-visit services—do any of them trigger reviews or denials related to medical necessity?
- It is important to understand how to code these services correctly under ICD-10.
- Update your superbill/billing form to the most common codes and updated code sets. (eg. ICD-9 V codes to ICD-10 Z codes)
Additional Resources

Additional resources (including linkage to care):

American Academy of HIV Medicine
Referral Link
www.aahivm.org

American Medical Association
CPT home page
www.ama-assn.org/go/cpt

HIV Medicine Association
HIV Provider Listing
www.hivma.org

National Clinician’s Consultation Center
Compendium of state laws regarding HIV testing
http://www.ucsf.edu/hivcetr/stateLaws/index.html

Centers for Disease Control and Prevention
CDC’s National Prevention Information Network
(800) 458-5231
www.cdcnpin.org

CDC revised recommendations
on routine testing for HIV
www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

Centers for Medicare and Medicaid Services
Medicare Coverage Center
www.cms.gov/center/coverage.asp

For more information contact:

American Medical Association
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Chicago, IL 60654
(312) 464-4147

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(202) 659-0699