Billing for HIV Services

The following HIV services are on the Non-chargeable List and are <u>non-billable</u>:

1. HIV/AIDS Counseling and Testing
2. STI Diagnosis and Treatment for individuals <19 years
3. STI Outreach
4. Infectious Disease Testing

The following HIV services *<u>are</u>* billable services:

1. Diagnostic and Evaluation Service (DES)
2. Case Management Services
3. Visits

<u>Self-referral Services</u>

https://mmcp.dhmh.maryland.gov/healthchoice/Pages/Home.aspx

As defined in the HealthChoice regulations, Maryland Medicaid Managed Care Program, COMAR 10.09.62, are ***"health care services for which under specified circumstances, the MCO is required to pay, without any requirement of referral by the primary care provider (PCP) or MCO when the enrollee accesses the service through a provider other than the enrollee's PCP."***

While MCO members are required to use in-network providers for most medical services, under certain circumstances, MCOs are responsible for some out-of-network care received by their members. These circumstances and payment requirements are defined in COMAR 10.09.67.28 under Benefits-Self-Referral Services and COMAR 10.09.65.20 under MCO Payment for Self-Referred Emergency and Physician Services.

*<u>Please note that if the LHD is **not** contracted with the MCO the LHD may need to obtain an authorization number from the MCO.</u>*

The circumstances under which MCOs **must pay** for out-of-network care can be classified into three types:

- Self-referral provisions for all MCO members;
- Continuity of care for new MCO members; and
- Emergency care provisions.

<u>HIV/AIDS Annual Diagnostic and Evaluation Service (DES)</u>

Type of Provision: Self-Referral

HealthChoice members diagnosed with human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS) are entitled to one self-referral annual diagnostic and evaluation service (DES) assessment provided by an approved HIV DES provider.

MCOs are responsible for reimbursing DES providers for an annual HIV assessment provided to MCO members with HIV/AIDS.

The following conditions must be met:

- A comprehensive medical and psychosocial assessment or reassessment must be provided.
- A written, individualized plan of care by a multi-disciplinary team convened by an approved HIV DES provider must be developed or revised and completed on a form approved by the Program.
- A copy of the completed pediatric or adult plan of care, which has been signed by all members of the multi-disciplinary team and the recipient or legally authorized representative, must be sent to the recipient's primary medical provider (PCP) and MCO.
- The procedure code to be used for billing the annual diagnostic and evaluation service (DES) is: **S0315**. The DES provider should bill the MCO on the invoice form specified by the MCO within 6 months.
- The MCO must reimburse the DES provider the current Medicaid rate.

Maryland Medicaid HIV Codes

(Effective 2/1/2012; see 12/21/11 Transmittal No.1)

Procedure Code	Service	Unit of Service	Max Rate per Unit
S0315	Diagnostic Evaluation Services (DES)	One	$200.00
W0316	HIV Ongoing Case Management	15 minutes	$17.86

HIV Testing Documentation

First visit consists of:

- The signed HIV consent form
- HIV test results
- Notation that the test results were communicated to the patient

Second visit consists of:

- 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 Counseling without Testing

- Written justification that counseling was provided
- The reason why the patient declined testing
- The follow up care plan, including indications for further counseling and testing

HIV Counseling Documentation

Initial visit for *confirmed positive results* consists of:

- Preliminary or confirmatory positive test results
- Referrals for medical care and supportive services

- Follow up to confirm continuum of care
- Prevention/risk reduction counseling and follow up care plan
- Partner counseling and assistance including domestic violence screening
- Medical Provider HIV/AIDS Report and Partner Contact Form

Annual assessments consist of:

- Prevention/risk reduction counseling and follow up care plan
- Partner counseling and assistance including domestic violence screening

While various state Medicaid agencies suggest the use of the rapid HIV test, it is the health care provider's discretion to order a rapid HIV screen or the conventional HIV screening test. Contact your local Medicaid agency for specific guidance.

Rapid HIV tests – G0435, 86701, 86702 and 86703

- Orasure Technology – specimen collection kit
- Trinity Biotech Uni-Gold
- One test payable every 6 months

Venipuncture – blood sample

- CPT 36415 – routine venipuncture

Using Modifiers for Billing

What are Modifiers?

Modifiers are typically used with procedure codes (CPT codes). Modifiers are two-digit (numeric or alpha numeric) codes that indicate that a procedure or service has been altered by a specific circumstance, but has not changed the code's definition.

- There are CPT code modifiers and HCPCS code modifiers
- Some modifiers impact reimbursement
- Modifiers are never reported alone
- Each state Medicaid agency determines which codes require modifier usage
- Contact your local Medicaid agency for specific guidance

Modifiers commonly reported with HIV Services

- **Modifier 25** - Significant, Separately, Identifiable E&M Service by Same MD on the Same Day of a Procedure, Service or Other E&M Service
    - Only report with E&M service codes (99201-99499)
    - Do NOT report with lab codes
    - Do NOT report with HCPCS codes
    - Contact your local Medicaid agency for specific guidance

- **Modifier ET** – report this modifier on all in-office lab tests performed on United Health Care Community Plan MCO patients *(if the lab service is not included on the non-chargeable list)*