BILLING CODING GUIDE FOR HIV PREVENTION

PrEP, SCREENING, AND LINKAGE SERVICES

NASTAD

NASTAD is a member of the **CBA Provider Network** and has a long history of providing technical assistance and Capacity Building Assistance (CBA) to health departments to support HIV testing. This document is part of NASTAD's Sustainability and Innovation CBA resources. This and other resources are available for download at **www.NASTAD.org**.

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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. While some of the services are provided in traditional healthcare settings and can be billed to public and private insurance, some of these services are provided in non-traditional settings by non-licensed professionals making it a challenge to bill insurance for these services. 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.

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DISCLAIMER

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Introduction

Health department HIV prevention programs and the medical providers they support offer a range of vital prevention services—including HIV Pre-exposure prophylaxis (PrEP) access services, linkage to care services, adherence counseling and HIV testing. Some of these services are performed by physicians, APRNs or 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 insurance companies for these services can be problematic, depending upon whether the payer (e.g., Medicare, Medicaid or private insurance plans) recognizes the service, the credentials of the person proving 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). Medical practices and health departments are being encouraged to bill patients' insurance for reimbursement for these important services. This coding guide will describe procedure (CPT®) and diagnosis code (International Classification of Diseases, 10th revision, Clinical Modification, ICD-10) that health care professionals can use when submitting claims for reimbursement for these important services.

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CODING OVERVIEW AND OBSTACLES TO PAYMENT

Insurance companies pay for services that are described by a CPT® code and performed by a licensed practitioner or for work performed under the supervision of a licensed practitioner. Services are paid based on a fee associated with each CPT® code. In some instances, a set of services will be reimbursed at a "bundled" rate instead of based on fee-for-service. (A bundled payment covers multiple services, and may include services provided by two or more providers for a single episode of care.) The American Medical Association develops these CPT® codes to describe services performed by healthcare providers. 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.

[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; CMS Presentation "Medicaid Preventive Services Regulatory Change" Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, April 2014, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf.

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All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code in order to be reimbursed. A medical practice or 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.

In summary . . .

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

- Described by CPT® code,
- Performed by a licensed provider (credentialed for the provision of services by the payor) or under the supervision of the credentialed licensed provider, and
- Supported by an allowable ICD-10 diagnosis code.

THE GOAL OF THIS GUIDE

The goal of this coding guide is to describe scenarios for PrEP initiation and follow-up, adherence, linkage and other counseling services, and for lab tests for HIV and other STIs. It will discuss CPT® codes and ICD-10 diagnosis codes that could be reported as part of filing a claim with the patient's insurance company or government payer. It will also include a discussion of who may provide this service either directly or under the supervision of a licensed medical 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 or for which there is not a covered ICD-10 diagnosis code. This limits the ability to seek reimbursement from the insurer for the service.

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PrEP initiation and follow up in medical offices and clinics

Prior to receiving a prescription for PrEP, an individual needs counseling and lab testing. The Centers for Disease Control and Prevention (CDC) has published Clinical Guidelines for PrEP.[2] Lab tests must be ordered by a physician, advanced practice nurse or physician assistant. If the counseling is done by one of these professionals, this counseling can be billed in one of three ways:

1. Office/outpatient facility submits a claim for a new or established encounter with a billable provider (physician, APRN or PA) and all other services using appropriate CPT codes linked to the allowable ICD-10 diagnostic codes;

2. Office/outpatient facility submits a claim for a shared medical appointment provided by a billable provider and all services provided; or

3. Office/outpatient facility submits a claim for "Preventive health counseling" proved by a billable provider for patients who don't have an established diagnosed illness.

[2] CDC PrEP Clinical Guidelines, available at http://www.cdc.gov/hiv/pdf/prepguidelines.pdf

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MEDICAL OFFICE VISITS FOR PrEP INITIATION

Codes: Evaluation and Management (E/M) services

99201–99205 for "new" patients
99211–99215 for "established" patients.

Who can perform: Credentialed physicians, APRN, and PAs

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed provider?

Note: Insurance companies and state Medicaid programs develop their own rules about services performed by a staff member "incident" to a licensed clinician and supervised by the clinician. This guide addresses the Medicare rules and many state Medicaid programs and private insurance companies follow these rules.

A staff member who is not a physician, APRN, or PA may only report the lowest level established patient visit, 99211. This code, 99211, is commonly known as a "nurse" visit. For Medicare, or payers that follow Medicare rules, this must meet "incident to" guidelines.

How to use the E/M codes:

- Select the level of service based on the history, exam and medical decision making.
- If counseling dominates the visit, use time in minutes to select the code. Document the total face-to-face time of the service, the statement that more than 50% of the time was spent in discussion and the nature of the discussion (e.g., I spent 15 minutes in face-to-face with Mr. XXX discussing the risks, benefits, limitations, possible complications, dosing, importance of adherence, and required conditions for continued prescribing of PrEP. He voiced an understanding and wishes to proceed).

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SHARED MEDICAL VISITS

Codes: Use CPT® codes 99201–99205 for "new" patients, 99211–99215 for "established" patients

Who can perform: These codes (99201–99215) may only be reported by physicians, APRNs, and PAs.

Location: Office, clinic or outpatient department

Can a staff member perform the services under the supervision of a licensed provider?

No. These E/M codes cannot be used for that purpose. A staff member could participate in the shared medical appointment with the licensed clinician, but the physician, APRN, or PA would need to document the services in the patient's record.

How to use these codes for shared medical appointments:

Some medical groups use the office/outpatient codes to report a shared medical visit.

- Neither CMS nor CPT® has commented in their manuals on the use of office visit codes for this purpose.
- The American Association of Family Physicians (AAFP) has published a notification of a communication with CMS, allowing this.[3]
- The billing physician, APRN, or PA may see the patient in the presence of other group members, but must document in each patient's chart.
- Select the level of service based on the key components (history, exam and medical decision making) documented for each patient, not based on the time of the group.

NOTE: There is a code for group services, 99078. Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions). It has a status indicator of bundled, so it would not usually be paid. CMS assigns status indicators to CPT® codes. The most common are "active," "non-covered" and "bundled." An "active" code is paid by Medicare and most payers. A "non-covered" status indicator means that the service is not covered by the payer but may be billed to the patient. If a CPT® code has a status indicator of "bundled," it is not paid by the payer and typically cannot be billed to the patient.

[3] American Association of Family Physicians (AAFP), CMS Coding Notification, available at http://www.aafp.org/practice-management/payment/coding/group-visits.html

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PREVENTIVE MEDICINE CPT CODES

Prior to receiving a prescription for PrEP, a medical professional has a discussion with the patient and orders lab testing. As mentioned above, these discussions may be reported by billable health care professionals using individual office visit codes or with a shared medical appointment. However, an alternative is to bill for the counseling with "preventive medicine" codes. CPT® has a series of preventive medicine codes for risk factor reduction. The preventive medicine codes are intended to be used in the absence of an established diagnosis.

Codes:

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

Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure);

99411 approximately 30 minutes
99412 approximately 60 minutes

Who can perform: physicians, APRNs, or PAs

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed provider?

It would be prudent to ask payers if these counseling services could be performed by a staff member under the supervision of a physician, APRN, or PA.

How to use these codes:

- These time-based codes are used to document preventive counseling in patients without a diagnosis. Counseling for PrEP adherence in patients without HIV fits into this description.
- According to the CPT® book, "Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment."[4]
- The codes in the 99401–99404 series are for individual counseling and codes 99411 and 99412 are for group counseling.
- Document the time of the face-to-face counseling in the medical record, and describe the counseling.
- These codes have a status indicator of "non-covered" for Medicare, but some private payers recognize and will reimburse for them.

[4] 2016 Current Procedural Terminology, American Medical Association.

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Diagnosis coding

A list of relevant diagnosis codes is at the end of this guide. For the purposes of PrEP counseling, many groups use **ICD-10 Z20.2** "Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission." Two other commonly used codes are:

- **Z11.4** "Encounter for screening for human immunodeficiency virus [HIV])" and
- **Z11.3** "Encounter for screening for infections with a predominantly sexual mode of transmission."

LABS FOR PrEP INITIATION

The lab tests described below are ordered by a billable healthcare professional prior to PrEP initiation. They may also be ordered in other situations for HIV and STI screening.

Prior to starting PrEP, the billable healthcare professional orders screening laboratory tests. These include HIV serology, and screening for sexually transmitted infections. The medical provider may also order a metabolic panel and/or pregnancy test.

After starting PrEP medication, the medical provider will order surveillance lab tests every three-months. Although screening for HIV has an "A" rating from the USPSTF and is covered without a "patient due balance," insurers may not treat the tests provided every three months in the same way. The more frequently obtained HIV tests may be considered diagnostic, rather than screening, once treatment is initiated. As a result, patients may have a co-pay and/or deductible for these lab tests.

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Code	Description
86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)
	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)
	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 immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme- linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) 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, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent asssay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening

Please see the discussion of modifiers after the HIV testing section of this guide.

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ICD-10 Code	Description	Use for
Z01.812	Encounter for preprocedural laboratory examination	Use for blood or urine tests prior to 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
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
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
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.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.
	Opioid abuse—no specific code for IV use	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.10	Opioid abuse, uncomplicated	
F11.90	Opioid use, uncomplicated	

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Adherence, linkage and other counseling services

PrEP ADHERENCE COUNSELING BY A PHYSICIAN, ADVANCE PRACTICE REGISTERED NURSE (APRN), PHYSICIAN ASSISTANT (PA)

Adherence counseling performed in a physician office may be billed with the same codes as listed in PrEP initiation, 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 is a code for high intensity behavioral counseling to prevent STIs, which can be billed in primary care settings, G0445. There are restrictions on G0445, described below.

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HIGH INTENSITY BEHAVIORAL COUNSELING TO PREVENT STIs

Code: G0445: Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to- face, includes education skills training & guidance on how to change sexual behavior, 20–30 minutes

Who can perform: The patient must be referred by a primary care provider to be eligible to receive this service, according to Medicare. Physicians, APRNs, and PAs may provide the service.

Location: A primary care setting.

Can a staff member perform the service under the supervision of a licensed provider?

It would be prudent to ask payers if these counseling services could be performed by a staff member under the supervision of a physician, APRN, or PA.

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 were having sex under the influence of alcohol or drugs, those were having sex in exchange for money or drugs, age (24 years or younger and sexually active for women with chlamydia and gonorrhea), those who have had an STI within the past year, IV drug use (hepatitis B only), and for men those are having sex with men and engaged in high-risk sexual behavior.
- The patient must be referred for this service by a primary care provider and the service must be provided by a Medicare-eligible primary care provider in a primary care setting. For the purpose of this service, Medicare defines a primary care physician as someone who is a general practitioner, family practitioner, general internist, or an obstetrician or gynecologist, or a geriatric medicine physician or pediatric medicine physician or a clinical nurse specialist, a nurse practitioner, or physician assistant.
- A primary care setting is describe as one in which the provision of integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.[5]
- This would seem to require that the patient was referred by one of the primary care specialty physicians listed above, it could be provided in a health department or infectious disease practice the provided majority of the patient's care.
- These codes could be used for HIV negative or positive individuals.

[5] Department of Health and Human Services, CMS, MLN Matters MM7610

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CHRONIC CARE MANAGEMENT (CCM) SERVICES

As of this writing, one year after CMS allowed payment for chronic care management codes, provider billing for these services remains very limited. CMS allows for a physician, APRN, or PA to bill for services provided by staff members in coordinating care and providing non-face-to-face services to patients. However, the restrictions and difficulties of 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 probably be used infrequently.

Code: 99490: chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following elements:

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

The problems must be of the type of conditions that pose a risk to the patient's health and well-being.

Who can perform:

Clinical staff under the supervision of a physician, APRN, or PA

Location: Office, clinic or outpatient department

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 practice must use a certified electronic health record.
- 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 plan: 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 the practice 24 hours a day, seven days a week.
- One provider must be designated for continuity of care.

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Care management includes assessment of the patient's medical, functional and psychosocial needs manage care transitions, and coordinate 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 care management services at any time.
- Document these communications in the record, and give the patient a written or electronic copy of the care plan.

Supervision of clinical staff is general, not direct, supervision. That means the billing provider does not need to be in the suite of offices when the clinical staff provides the non-face-to-face care.

The practice 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.

Key points

- Work is done by clinical staff.
- May not count any clinical staff time on a day when the physician or qualified healthcare professional (APRN/PA) has an evaluation and management service with the patient.
- E/M services may be reported during the same calendar month the chronic care management is provided.

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SCREENING AND BEHAVIORAL COUNSELING IN A PRIMARY CARE SETTING 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 specialties 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.

Codes:

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

Who can perform: Physicians, APRNs, or PAs

Location: Office, clinic, outpatient department or local or state health department

Screening can be performed in any location. Counseling is furnished by qualified physicians, advanced practice nurses and physician assistants in a primary care setting. These services may be provided to patients with or without HIV.

Can a staff member perform the service under the supervision of a licensed provider?

Medicare indicates that the counseling is performed furnished by "qualified primary care physicians or other primary care practitioners in a primary care setting."

How to use these codes:

Medicare states: For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443. Infectious Disease is not a specialty on CMS' list.

- 01-General Practice
- 08-Family Practice
- 11-Internal Medicine
- 16-Obstetrics/Gynecology
- 37-Pediatric Medicine
- 38-Geriatric Medicine
- 42-Certified Nurse Midwife
- 50-Nurse Practitioner
- 89-Certified Clinical Nurse Specialist
- 97-Physician Assistant

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For purposes of this covered service, the following Place of Service (POS) codes are applicable:

- 11 Physician's office
- 22 Outpatient hospital
- 49 Independent clinic
- 71 State or local public health clinic

The screening is covered annually by Medicare and up to four brief interventions are covered annually. State Medicaid programs and private payers may have their own rules and frequency limitations.

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:

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

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

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

4. **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.

5. **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.

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CARE COORDINATION, LINKAGE AND ADHERENCE SERVICES BY COMMUNITY HEALTH WORKERS (CHWs) AND OTHER NON-LICENSED/ PEER PROVIDERS 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 CWHs, 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[6]

This allows CHWs or other non-licensed professionals to perform and bill Medicaid for services that would typically only be billed by physicians, advanced practice nurses or physician assistants. 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.

If so, there are 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.

Codes:

98960 Self management education and training face-to-face, 1 patient
98961 Self management education and training face-to-face, 2–4 patients
98962 Self management education and training, face-to-face, 5–8 patients

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed professional?

Check with your state Medicaid program and private insurers.

- 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 CHWs or other non-licensed professionals.
- CPT® describes these services as performed by a physician, APRN, or PA, so check with your private insurers about CHWs or other non-licensed professionals performing them under the supervision of those licensed professionals.

[6] CMS Presentation "Medicaid Preventive Services Regulatory Change" Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, April 2014, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf.

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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 isn't recognized and paid by insurance companies. There are codes for this work described by the Healthcare Common Procedure Coding System (HCPCS). HCPCS codes are developed by CMS for its own use, but the codes are often also recognized by state Medicaid programs and commercial payers.

Codes:

T1017 Targeted case management, each 15 minutes

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. For example, the state of Mississippi allows the service to be billed in the patient's home, in a school, in a community mental health center and in "other place of service not identified."[7] Texas allows targeted case management to be performed over the phone or face-to-face using these codes. The provider should append modifier IU when the service is performed face-to-face.[8] Florida Medicaid pays for targeted case management using these codes for group services.[9] 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 targeted case management.

Who can perform: This is a case management service, and may be performed by CHWs.

Location: Check with the state Medicaid program.

How to use these codes: Use these codes for case management services performed by CHWs. Document time in the medical record.

[7] Community/Private Mental Health Center Billing Guidelines, available at https://www.medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf.

[8] 2012 Texas Medicaid Provider Procedures Manual, Targeted Case Management, available at http://www.tmhp.com/HTMLmanuals/TMPPM/2012/Vol2_Children's_Services_Handbook.17.081.html.

[9] Florida Medicaid, Mental Health Targeted Case Management Handbook, available at http://www.flatherapy.com/therapy/wp-content/uploads/2010/05/CTCM-Handbook.pdf.

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MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

When a mental health assessment is performed by a physician, APRN, or PA, the clinician use E/M codes. Psychiatrists, social workers and psychologists use psychiatric diagnostic interview codes, in the Psychiatry section of the CPT® book when performing an initial evaluation. Some state Medicaid programs allow payment for a mental health assessment by non-licensed professionals, who are not listed above and not able to use the CPT® codes to report the evaluation.

Code: H0031: Mental health assessment, by non-physician

This code is not covered by Medicare, but may be covered by state Medicaid programs. Groups and organizations need to check with their individual state Medicaid programs. The service will typically be covered once per year. There may be diagnosis related restrictions related to the evaluation. It would be prudent to review if there are restrictions based on age, that is, if the service is only covered for children. One managed Medicaid program limits this to one assessment per year and does not require a prior authorization. This may require modifier "MO" indicating a master level provider has done the assessment.[10] Medicaid in the state of Georgia covers the service and has variable payment depending on the credentials of professional performing it.[11]

Who can perform:

Although this will vary by state, the code is applicable to trained para-professionals.

Location:

The service may be covered when done in a school, the patient's home or in some cases, in "other place of service."

How to use this code:

The provider must document a mental health assessment that includes the patient's past history, social, and family history. The assessment should include documentation of the patient's current functioning and an assessment of mental status. The history includes education, employment and any legal involvement as well as relationships and living environment. Document use of alcohol, tobacco and other drugs and behaviors that put the individual at risk.

[10] Magellan of Florida, Behavioral Health Therapy Services, available at https://www.magellancompletecareoffl.com/media/916790/appendix_k_combined.pdf.

[11] Georgia, Medicaid State Plan, Policy and Methods for Establishing Payment Rates for Other Types of Care for Services, available at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GA/GA-11-007-Att.pdf.

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Lab tests for HIV and other STIs

HIV SCREENING

Testing in the setting or PrEP initiation and adherence was discussed earlier in this guide, but the same CPT® codes are used for screening for HIV and other STI in other settings and situations.

Codes: HIV screening has an "A" rating from the USPSTF. It is a covered service by Medicare, Medicaid and commercial insurance companies. The USPSTF has not recommended specific screening intervals, but does describe recommendations for those intervals. That discussion is below.

PROCEDURE CODES

Code	Description
86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)
	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)
	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 immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme- linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) 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

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HCPCS code	Description
	Screening for Medicare patients
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent asssay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening

Modifiers are two-digit codes that are added to a procedure code when submitting a claim to an insurance company. These two digit modifiers do not change the definition of the code, but inform the payer of special circumstances related to the provision of the service.

There are three modifiers that could be used when screening for HIV.

- Use of modifier 33: In response to the ACA, CPT® developed a modifier to be used when a service is provided that is a service that carries an "A" or "B" rating from the USPSTF (and is thus required to be provided without patient cost sharing). Modifier 33 **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 in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.[12] It is correct coding to append modifier 33 to any service that meets this description.

Use modifier 33 on the CPT code for HIV screening. This informs the payer that the service is a service recommended by the USPSTF. For patients with commercial policies, it insures that the insurance company will pay the claim without a patient due amount. No co-pay or deductible should be applied to a service with a USPSTF "A" or "B" rating.

- 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). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

Use this modifier on the HCPCS codes for Medicare patients, G0432, G0433, G0435.

Modifier QW CLIA waived test

- CLIA waived tests on this list are 86701, G0433, G0434 87389

[12] Current Procedural Terminology 2016, American Medical Association

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DIAGNOSIS CODES

ICD-10 Code	Description	Use For
Z11.4	Encounter for screening for 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
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
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

- The USPSTF recommends that all pregnant women be screened, and any woman who presents while in labor whose HIV status is unknown. It also recommends screening in individuals who are age 15–65, and states that younger and older individuals who are increased risk should be screened.
- Medicare has aligned its HIV testing coverage determination with CDC and USPSTF recommendations, allowing for one, annual voluntary screening for all adolescents and adults between the age of 15 and 65, without regard to perceived risk and testing three times per pregnancy for pregnant women. While all commercial carriers will cover the test, because the USPSTF does not give a frequency recommendation, commercial carriers and state Medicaid programs are free to develop their own guidelines. For example, Aetna simply quotes the USPSTF and does not specifically state what their frequency limitations are.[13]

UnitedHealthcare, in its National Coverage Determination N210.7 gives these frequency limits states that except for pregnant beneficiaries, it covers one annual screening. UnitedHealthcare's preventive medicine policy for screening for non-Medicare replacement plans lists the lab service as covered, but does not describe frequency. It can be assumed that it will have similar frequency limitations.

Complications

A screening test may be denied because:

- 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.

[13] Aetna, HIV Testing Policy, available at http://www.aetna.com/cpb/medical/data/500_599/0542.html

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HIV SCREENING IN A NON-PRIMARY CARE SETTING

An insurance company is required to cover any service given an "A" or "B" grade from the USPTSF. This includes HIV screening. (See the appendix for a table that lists related services with an A or B rating.) Emergency departments, conducting routine HIV screening of patients, have reported payment challenges. Details on the USPSTF HIV screening recommendations are available online.[14]

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.[15]
- Modifier 33 was not appended to the CPT® or HCPCS code.

[14] See U.S. Preventive Services Task Force. H. *Human Immunodeficiency Virus (HIV) Infection: Screening.* Release Date: April 2013, available at: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening.

[15] From the USPSTF regarding screening intervals: "The evidence is insufficient to determine optimum time intervals for HIV screening. One reasonable approach would be one-time screening of adolescent and adult patients to identify persons who are already HIV-positive, with repeated screening of those who are known to be at risk for HIV infection, those who are actively engaged in risky behaviors, and those who live or receive medical care in a high-prevalence setting. According to the CDC, a high-prevalence setting is a geographic location or community with an HIV seroprevalence of at least 1%. These settings include sexually transmitted disease (STD) clinics, correctional facilities, homeless shelters, tuberculosis clinics, clinics serving men who have sex with men, and adolescent health clinics with a high prevalence of STDs. Patient populations that would more likely benefit from more frequent testing include those who are known to be at higher risk for HIV infection, those who are actively engaged in risky behaviors, and those who live in a high-prevalence setting. Given the paucity of available evidence for specific screening intervals, a reasonable approach may be to rescreen groups at very high risk (see Assessment of Risk) for new HIV infection at least annually and individuals at increased risk at somewhat longer intervals (for example, 3 to 5 years). Routine rescreening may not be necessary for individuals who have not been at increased risk since they were found to be HIV-negative. Women screened during a previous pregnancy should be rescreened in subsequent pregnancies."

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Screening for syphilis

One annual screening for syphilis in men or women at increased risk. For pregnant women, one screening per pregnancy; two additional screenings in the third trimester and at delivery if at increased risk for STIs.

CPT® Code	Description
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-troponemal antibody; quantitative
86780	Treponema pallidum

Screening for gonorrhea

One annual screening for gonorrhea in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy who are at increased risk and who continue at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for gonorrhea in men, and this will affect payer policies. The ACA mandated that health insurers cover screening services that the USPSTF gives an A or B rating.

CPT® Code	Description
87590	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, quantification

Screening for hepatitis B

The USPSTF recommends screening for individuals at risk. Frequency is not described. For pregnant women, screening is recommended at the first visit. Medicare recommends and covers an additional screening at delivery if the individual is still at increased risk for STIs.

CPT® Code	Description
Infectious agent antigen detection by immunoassay technique, (eg, 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

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Screening for chlamydia

One annual screening for chlamydia in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy who are at increased risk and who continue to be at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for chlamydia in men.

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 immunoassay technique (eg, enzyme immunoassay {EIA}, enzyme–linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method, chlamydia trachomatis
87490	Infectious disease agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, direct probe technique
87491	Infectious diseases agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, amplified probe technique
87810	Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis

Other codes

CPT® Code	Description
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

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Appendix

COMMON DIAGNOSIS CODES

ICD-10 code	Description	Use for
Z01.812	Encounter for pre-procedural laboratory examination	Use for blood or urine tests prior to 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
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
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
	Opioid abuse—no specific code for IV use	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.10	Opioid abuse, uncomplicated	
F11.90	Opioid use, uncomplicated	
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.
Z72.89	Other problems related to lifestyle	Use for drug seeking behavior or unhealthy drinking behavior
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.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.

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PREGNANCY RELATED DIAGNOSIS CODES

ICD-10 code	Description
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
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 other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z32.00	Encounter for pregnancy test result unknown
Z32.01	Encounter for pregnancy test result positive
Z32.02	Encounter for pregnancy test result negative

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CPT® CODES

CPT® Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
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.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

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CPT® CODES (continued)

CPT® Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	approximately 35 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
98960	Self management education and training face-to-face, 1 patient
98961	Self management education and training face-to-face, 2-4 patients
98962	Self management education and training face-to-face, 5-8 patients
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to- face, includes education skills training & guidance on how to change sexual behavior, 20-30 minutes
HCPCS code	**Description**
T1017	Targeted case management, each 15 minutes
H0031	Mental health assessment, by non-physician
CPT® Code	**Description**
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
80053	Comprehensive metabolic panel
82565	Creatinine; blood
82570	Creatinine other source (urine)
82575	Creatinine clearance

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UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDATIONS

Population	Recommendation	Grade
	HIV SCREENING	
Adolescents and Adults 15–65 Years Old	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. Go to the Clinical Considerations for more information about screening intervals.	A
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
	ALCOHOL MISUSE SCREENING	
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I
	CHLAYMIDIA AND GONORRHEA	
Sexually Active Women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B
Sexually Active Women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B
Sexually Active Men	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.	I
	HEP B IN PREGNANT WOMEN	
Pregnant Women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A
	HEP B AT HIGH RISK FOR INFECTION	
Persons at High Risk for Infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.	B
	HEP C	
Adults at High Risk	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering 1-time screening for HCV infection to adults born between 1945 and 1965.	B
	HIV	
Adolescents and Adults 15–65 Years Old	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. Go to the Clinical Considerations for more information about screening intervals.	A

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UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDATIONS (continued)

Population	Recommendation	Grade
	HIV	
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
	SYPHILIS IN PREGNANCY	
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A
	SYPHILIS SCREENING	
Persons at Increased Risk	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A
Pregnant Women	The USPSTF strongly recommends that clinicians screen all pregnant women for syphilis infection.	A
Asymptomatic Persons, Not at Increased Risk	The USPSTF recommends against routine screening of asymptomatic persons who are not at increased risk for syphilis infection	D
	COUNSELING-ALCOHOL	
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I
	COUNSELING-BEHAVIORAL	
Sexually Active Adolescents and Adults	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).	B

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Glossary

AMA	American Medical Association
APRN	Advance Practice Registered Nurse
CCM	Chronic Care Management
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CHW	Community Health Workers
E/M	Evaluation and Management
HCPCS	Healthcare Common Procedure Coding System
HIV	human immunodeficiency virus
ICD-10-CM	International Classification of Diseases, 10th revision, Clinical Modifications
NASTAD	National Alliance of State & Territorial AIDS Directors
PA	Physician Assistant
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
USPSTF	United States Preventive Services Task Force

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