



Introducing NASTAD's PrEP, PEP, and Other HIV Prevention Strategies: Billing and Coding Guide Webinar: Frequently Asked Questions (FAQ)

Following the October 18 webinar, "[Introducing NASTAD's updated Pre-Exposure Prophylaxis \(PrEP\), Post-Exposure Prophylaxis \(PEP\), and Other HIV Prevention Strategies: Billing and Coding Guide](#)", NASTAD developed an FAQ with questions asked during the webinar. Questions and answers are listed below in the order in which they were asked.

For those that were unable to ask their question, have had questions since the October 18 webinar, or don't see their question answered below, please share your question [using this form](#). NASTAD will review questions and continue to add to this FAQ document.

Q1. Can Z29.81 be used retroactively?

A1. No. Z29.81 is effective from 10/1/23 and on. It will not be effective for claims before date of service 10/1/2023.

Q2. Clarifying question: Can a Preventive Z-code ICD 10 diagnosis (like the new Prep code Z29.81, or code Z20.6 for suspected HIV exposure) be the primary diagnosis for an office visit that is billed as an E&M CPT (99212-99215)? Or do you have to bill that visit with both the preventive CPT and the E&M CPT?

A2. The Z codes typically represent reasons for a service in the absence of signs, symptoms, illness, or injury. While it may be typical, it is not without exception.

Z29.81 represents a reason for a visit that is preventive. Therefore, Z29.81 will be billed with the Preventive Counseling codes 99401-99404, not with the E&M CPT codes (99212-99215). This is a PrEP visit.

Z20.6 represents a reason for a visit that is not preventive. The client has had contact with (or suspected contact with) HIV. The patient has presented with a problem that must be evaluated and managed. Therefore, Z20.6 will be reported with E&M CPT (99212-99215). This is a PEP visit.

These two scenarios could not occur for the same patient on the same day as they would either have had an exposure or not had an exposure.

Q3. Are FQHCs using Community Health Workers for HIV prevention and if so are you getting reimbursed for the service?

A3. Because reimbursement varies so much by region, this question is best answered by other FQHCs in your state. For Medicaid programs, each state defines eligible providers for FQHC encounter rate reimbursement. Check with your state Medicaid program.

For Medicare, the answer is no, CHWs are not qualifying providers. Therefore, services provided by them would not be eligible for reimbursement. Reference Medicare Claims Processing Manual Chapter 9 and the Medicare Benefit Policy Manual Chapter 13 for FQHC qualifying provider requirements.

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf>

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For other non-government payors, contact the provider representatives to ask if there is any opportunity to enroll CHWs as participating providers. If CHWs cannot be enrolled as participating providers, ask the provider rep if these provider types may be billed under the supervision of a participating provider. Make sure you are clear about the payer policy and rules around supervision and billing.

Q4. What is the best practice for coding PrEP visits?

A4. When PrEP counseling is provided to a patient by a licensed and enrolled provider, report the service with;

- CPT® codes 99401-99404, Preventive medicine counseling and/or risk factor reduction intervention.
- ICD-10 code V29.81

Q5. What is the best practice for telePrEP visits?

A5. When TelePrEP counseling is provided to a patient by a licensed and enrolled provider, report the service with;

- CPT® codes 99401-99404, Preventive medicine counseling and/or risk factor reduction intervention.
- ICD-10 code V29.81
- Append technology modifiers are required by payer policy for telemedicine services

Q6. Did anyone catch when to use the modifier 25?

A6. Modifier 25 is defined by CPT® as a *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*. Modifier 25 is appended to Evaluation and Management codes when both services have been performed and documented in the medical record. Both the service and the reason for each service must be separately identifiable. If time is used as the determining factor when choosing a CPT® code, time may not overlap. A 15-minute PrEP counseling and a 15-minute E&M service require a minimum of 30 minutes of documented time.

Modifier 25 is powerful and should be used only when all documentation requirements are met. Some payers may require that medical record documentation is submitted with the claim.

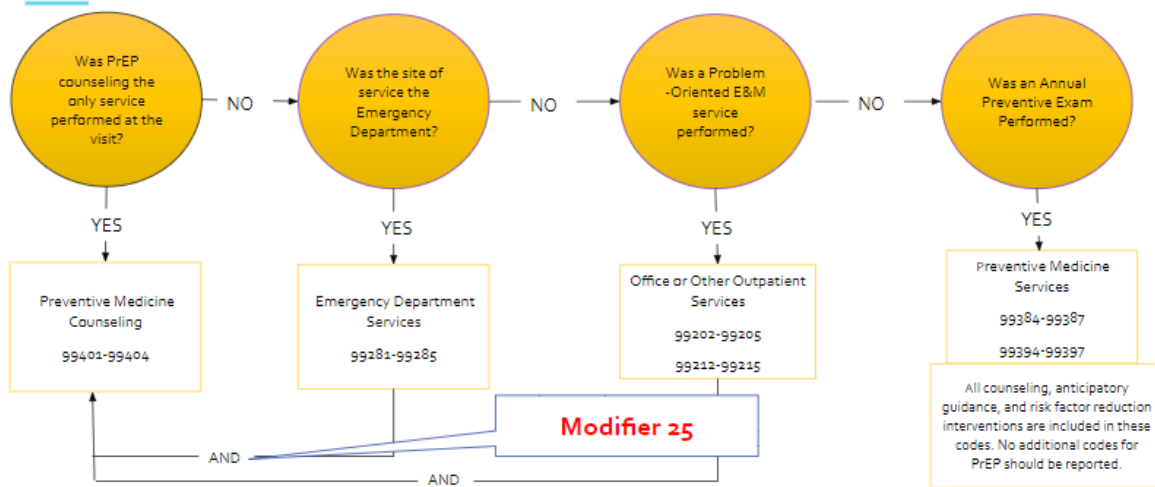
AMA Modifier 25 resources: <https://www.ama-assn.org/practice-management/cpt/setting-record-straight-proper-use-modifier-25>

<https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf>

There are two instances in this graphic below in which Modifier 25 might be applicable. Those instances are identified by the word AND. Because this webinar and guide are focused on HIV prevention, PrEP counseling the graphic below always assumes that PrEP counseling is performed. It may have occurred either alone or at the time of another service.

1. PrEP counseling is performed AND a medically necessary Emergency Department (ED) Service is performed during the same encounter bill both the Preventive Medicine Counseling code and an ED visit code.
 - a. 99401-99404 with ICD-10 code V29.81
 - b. 99281-99285 with ICD-10 code representing the reason for the ED visit.
 - c. Add modifier 25 to the ED Visit code
2. PrEP counseling is performed AND a medically necessary Office or Outpatient Service is performed during the same encounter bill both the Preventive Medicine Counseling code and an Office or Outpatient Service visit code.
 - a. 99401-99404 with ICD-10 code V29.81
 - b. 99212-99215 with the ICD-10 code representing the reason for the Office visit service.
 - c. Add modifier 25 to the Office Visit code (99212-99215).

PrEP E&M Counseling Decision Tree



Q7. Also, can the counseling code get paid alone outside of a regular E/M series? 99212-99215

A7. Yes. The counseling codes can get paid alone. If the reason for the encounter is for PrEP counseling only then the counseling code would be the only service code billed.

Q.8 I work with providers as an academic detailer. These questions frequently come up with providers. Any advice for reaching out to payers as someone who is not a clinical

provider? I frequently reach a dead end with payers because I am neither a provider nor a member.

A8. To speak with a provider representative at a payer, you will likely need the Tax ID number(TIN) and/or the NPI of the provider for whom you are working. Provider representatives are assigned to help participating providers. To get patient-specific claim information, you will always need the patient's information and permission.

However, payers are typically very good about publishing medical policies or coverage policies on the public pages of their websites. These published policies will answer general, reimbursement, and coverage questions without speaking with provider reps. Although providers may register for logins for each payer site, there are not many policies that are hidden behind the provider login.

Q9. Will they talk to a licensed provider if you are not seeking information about a specific member or claim? Getting through the phone trees makes that tricky if it is an option.

A9. Getting through a phone tree without a provider TIN or NPI is very difficult. My recommendation is to start with the website. If the information required is not available, then use the TIN or NPI of the participating provider with whom you are working.

Q10. What is E&M?

A10. Evaluation and Management. E&M codes are site-specific CPT® codes that represent medical visits during which providers evaluate and/or manage a patient's health.

Q11. For FQHCs, Medicare does not recognize codes 99401-99404 as qualifying visits that correspond to the specific payment codes. Any word that this may get updated or if they have a specific code to be used?

A11. Medicare is currently working on an NCD for PrEP. CMS originally set a publication date of 10/10/2023 but that has been delayed. We expect to get an update in the first few weeks of November. In the meantime, continue coding the PrEP visits as you have in the past, but add the new ICD-10 code to the claim. These claims can be corrected in the future once the NCD is published and CMS updates the FQHC payment codes to include the new language.

Q12. Can someone help explain what and when to use modifier 33? When do we use mod 33?

A12. Modifier 33 is used to identify that the primary purpose of a service is to deliver an evidence-based preventive service based on the recommendations of the USPSTF. This modifier alerts the payer that this service should be processed without cost share to the patient. Append Modifier 33 to any CPT® code that is not preventive by definition. The most common examples include lab testing which is not defined as a screening test. Always refer to payer policies for guidance on Modifier 33 usage.

Q13. What is USPSTF?

A13. The [USPSTF](#) is the United States Preventive Services Task Force.

Q14. When should we use Mod KX?

A14. When a gender-specific procedure or diagnosis code doesn't match the patient's reported sex, modifier KX (and all requirements specified in the medical policy have been met) should be appended to the CPT® code to the claim. This will override gender conflict edits in the payer claim processing system.

For the purposes of PrEP, Modifier KX would be used when billing STI testing that is covered only for women. This typically includes chlamydia and gonorrhea. If a client is a transgender male, then modifier KX would be appended to the CPT® code that does not typically agree with or is covered by the patient's reported gender.

Q15. Can you use both mod 25 and 33 at the same time? If one is preventive and the other is with other issues For Office/Other Outpatient Services, do we use both codes?

A15. You can use both Modifier 33 and Modifier 25 on the same claim or even the same code.

However, in the case of PrEP visits that are performed during the same encounter as an E&M (Office/Other Outpatient Services), modifier 25 would be appended to the E&M code and if required the modifier 33 would be reported on the 99401-99404 codes. The "if required" language is used here because 99401-99404 codes are defined as Preventive Counseling. However, some payers require Modifier 33 to indicate that the counseling performed is a USPSTF Grade A or B preventive counseling service and should be processed without cost-share.

Q16. I understand that payers are still in the process of making updates, do we have an estimate on how long it will take to have these changes take place?

A16. While we cannot speak for the payers, we would anticipate that the changes needed to incorporate V29.81 into payer policies would be complete by mid to late November; 6-8 weeks after the effective date of the new ICD-10 code.

Q17. Will the old codes be voided?

A17. Payers may remove previously identified ICD-10 codes from the payer policies for PrEP. Typically, the payer will identify the new ICD-10 codes for dates of service on or after 10/1/2023 and leave the previously identified codes for services before 10/1/2023 either in the body of the policy or in a change history section.

ICD-10 codes may be deleted during an annual revision. ICD-10 did not delete any codes associated with PrEP or PEP services in the 2024 revision.

Q18 Can you address bill codes for patients who are treated for STI and PrEP care at the same visit? E/M 99212-99215 may include counseling. Is it recommended to separate the counseling under 99401-99403?

A18. If a patient presents for treatment of an STI and PrEP counseling occurs at the same visit, then the provider needs to determine if each service is significant and separately identifiable in performance and documentation. Both the E&M code and the Preventive Counseling codes must meet all documentation requirements. The time spent on each cannot overlap.

This is true for any problem-oriented visits at which PrEP counseling occurs. If both 99401 and 99212 are reported then the time spent with the patient must clearly indicate that the 15-minute threshold for 99401 is met and documented. Likewise, all documentation requirements for 99212 must be met and documented. Report the 99401 with V29.81 and report the 99212 with the ICD-10 for the diagnosed STI.

Q19. Is it not an issue to have a preventive and sick visit at the same time? I've been told this is not possible.

- A19. It is acceptable and possible to bill both preventive and sick visits on the same date for the same patient. These services must be significant and separately identifiable in the documentation. Requirements for this scenario include;
- Perform and document all elements of the preventive service and report with a preventive ICD-10 code
 - Perform and document all elements of the significant and separately Identifiable sick visit (problem-oriented or E&M) service and report with an ICD-10 code representing the symptoms or illness.
 - Do NOT overlap time. The time for each visit must be calculated and documented separately.
 - Append Modifier 25 to the E&M code if the sick visit was *Significant and separately Identifiable*.
 - Modifier 25 is powerful and should be used only when all documentation requirements are met.

Q20. If the patient has other health coverage under their employer insurance is there a workaround such as if the patient has coverage under managed care or Medi-Cal?

A20. Providers/billers are required to determine which insurance is the primary payer. That primary payer is billed. Once the claim is processed the subsequent payer may be billed with the explanation of benefits from the primary payer attached. Medi-Cal or/and any Medicaid program is always the payer of the last resort. There is no workaround to avoid the primary payer. Whether the primary payer contract is a fee-for-service, capitated, or encounter rate, the claim must be processed by the primary payer before submitting it to the second or subsequent payer.

Q21. What are the best practices for communicating with insurance companies about this new code? What about pharmacies? and labs?

A21. The best practice is to start reporting the new ICD-10 code on claims. If denials occur due to the use of Z29.81, call the organization that is not recognizing it and share the guide.

Q22. We are having difficulty getting the appropriate dosage to bill for insurance - it is showing only 1mg rather than 600mg no matter how we inventory and bill it.

A22. Every practice management system (billing system) handles units differently. Request a meeting with the EHR/PM system company to make sure the charges are crossing from the EHR to the billing system and then to the claims appropriately. If it were me, I would request an edit for this code if this code is entered with anything less than 600 mgs. Those functional edits could be at the provider screens, charge processing, and at claim editing.

Q23. How can attorneys help ensure compliance with reimbursement requirements?

A23. The Affordable Care Act (ACA) requires most private insurance plans to cover PrEP - including the medication, labs, and medical visits - without cost sharing. If a plan denies coverage for a PrEP service or charges a patient any cost sharing for the service, the provider and/or patient should appeal. The billing and coding guide includes a template for providers to use to appeal plan coverage denials or erroneous cost sharing. If a plan does not rectify the inappropriately processed claim, patients should consider filing an appeal with the entity that regulates their plan. NASTAD has developed a [template](#) that patients can use to identify what entity regulates their plan and to develop a complaint that cites relevant laws, regulations, guidance. Any complaint should also reference the [NASTAD billing and coding guide](#).