Coding and Billing



OraSure Technologies is pleased to provide you information on billing and reimbursement for HCV testing with the OraQuick® HCV Rapid Antibody Test. Correctly identifying services delivered when performing HCV testing will help you secure accurate and timely reimbursement.

The information provided inside is for illustrative purposes only. As policies change frequently, we would strongly recommend that you consult the specific payer for any questions that arise when completing or submitting a claim for services.

Commonly Asked Questions

Q1.

What codes are available to describe testing with the OraQuick[®] HCV Rapid Antibody Test?

A1.

Since OraQuick[®] is a simple test that provides results for HCV, the Healthcare Common Procedural Coding System (HCPCS/CPT) code 86803 should be used for common insurance carriers along with the QW or in some cases 92 modifier code, while Medicare submissions should use HCPCS/CPT code G0472 with the QW modifier (See Table 1). The 92 modifier means that this is an alternative laboratory platform test being performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber (rapid test). The QW modifier means the test is CLIA-waived. The addition of these modifiers should not affect the payment amount, but some payers require notification that the test is being performed in a CLIA-waived setting.

Q2.

What is the reimbursement rate to perform the test?

A2.

The Medicare National Limitation amount (NLA) is the ceiling payment rate for Medicare carriers which is represented in Table 1. For a comprehensive state-by-state list, refer to <u>http://www.cms.gov/Medicare/Medicare-Fee-for-Service-</u>

<u>Payment/ClinicalLabFeeSched/clinlab.html</u>. However, you should check with your individual payer to determine coverage and coding requirements for the test.



Physician Office Reimbursement Guideline

Commonly Asked Questions-continued

Q3.

What ICD-9-CM, ICD-10-CM codes are available to describe a patient encounter for an OraQuick[®] HCV Antibody Test?

A3.

Good clinical judgment can be used to identify the appropriate diagnosis code of the patient encounter where the OraQuick® HCV Rapid Antibody Test was performed. Refer to Table 2 for a list of representative codes for both symptomatic and asymptomatic patients.

NOTE: *This is not a complete list.*

Q4.

What codes are available to describe the time I spend providing HCV test counseling services?

A4.

Several coding options exist under the evaluation and management (E & M) codes. Refer to the E & M 1995 / 1997 Guidelines for the appropriate determination. (See Tables 3 & 4)

For patients who have undergone testing but do not have an established illness, you can describe your harm reduction counseling using several different codes. (See Table 5)

NOTE: *Medicare may or may not reimburse CPT code 99401-99404. Consult your local Medicare contact for reimbursement eligibility.*

Q5.

I have been called in by another physician to provide HCV testing services. What codes are available to describe this encounter?

A5.

An HCV test result report and consultation services can be reported using a series of evaluation and management (E & M) codes. Refer to the 1995 / 1997 E & M Guidelines for the appropriate determination. (See Table 6)

NOTE: 99241-99244 codes may or not be reimbursed by Medicare payers. Consult with specific payer to determine appropriate *E* & *M* code.

Q6.

Is hepatitis C testing covered for the "baby boomer" population within my practice?

A6.

A risk assessment evaluation would have to be performed and well documented to be reimbursed. Hepatitis C testing is generally covered for people at risk. Consult with the individual payer to establish the criteria for reimbursement allowance.

Q7.

Do you have an example of a form I could use as a reference?

A7.

Yes, see the attached CMS-1500 form for an example of a physician office visit.

ICD-9-CM, ICD-10-CM, and HCPCS / CPT Codes

Table 1 – L	aboratory Test Codes	
CPT Codes	Description	Medicare Clinical Lab Fee Schedule National Limitation Amount
Correct Code		
86803	Antibody; HCV, qualitative or	\$19.42
-QW or -92	quantitative single assay	
HCPCS		
G0472	Antibody; HCV, qualitative or	
-QW	quantitative single assay	Not Available*
(J

Note: Commercial insurance plans may also implement G0472 or continue to utilize CPT Code 86803. Commercial carriers may require modifier -92 (alternative laboratory platform testing) when CPT 86803 is reported.

*Manually priced. Consult with local MAC for reimbursement allowance.

ICD-9-CM Codes	ICD-10-CM Codes	Description
		Birth Cohort Screening
V73.89	Z11.59	Screening examination; other specified viral diseases
V73.99	Z11.59	Screening examination;unspecified viral disease
V02.60	Z22.50	Carrier or suspected carrier of; viral hepatitis carrier, unspecified
V02.62	Z22.52	Carrier or suspected carrier of hepatitis C
V02.69	Z22.59	Carrier or suspected carrier of; other viral hepatitis carrier
		High-Risk Exposure
V01.79	Z20.828	Contact or exposure to other viral diseases
V73.89	Z11.59	Special screening examination for other specified diseases
V18.3	Z83.2	Family history; being born to an HCV-infected mother
		High-Risk Behaviors
042	B20	Human Immunodeficiency Virus (HIV) disease
V08	Z21	Asymptomatic HIV infection status
V69.2	Z72.51	High risk sexual behavior
		High Risk Drug-Use Behavior
V69.8	Z72.89	Self-damaging bahavior (required code for all high risk individuals)
571.8	K.76.89	Other chronic nonalcoholic liver disease
571.9	K.76.9	Unspecified chronic liver disease without mention of alcohol
V79.1	Z13.89	Screening for alcoholism
		Other Related Codes
790.4	R74.0	Non-specific elevation of ALT or LDH
796.4	R68.89	Other abnormal clinical findings
		Annualized High-Risk Drug Use Behavior (based on patient
1000	770.00	history assessment)
V69.8	Z72.89	Self-damaging behavior
304.91	F19.20	Unspecified drug dependence; continuous 304.00-304.93 Drug dependence by type
		Diagnoses Codes
070.51	B17.10	Hepatitis C, acute w/o hepatitis coma
070.41	B17.11	Hepatitis C, acute with hepatitis coma
070.54	B18.2	Chronic hepatitis C, w/o hepatitis coma
070.44	B18.2	Chronic hepatitis C, with hepatitis coma
070.70	B19.20	Unspecified viral hepatitis C, w/o hepatitis coma
070.71	B19.21	Unspecified viral hepatitis C, with hepatitis coma

Table 2 – ICD-9-CM, ICD-10-CM Diagnosis Codes

HCPCS / CPT Codes

Table 3 – Basic Office Management Codes

CPT Codes	Evaluation and Management Codes	Medicare Physician Fee Reimbursement Amount
Patient Visits		
99201 - 99215	Office visit new or existing patient	\$20.02 - \$207.02
Prolonged servi	ce with patients	
99354	Prolonged service in the office or other outpatient setting beyond usual serivce	\$100.11
99355	Prolonged service; each addtional 30 minutes	\$96.90

For more information: See https://www.cms.gov/apps/physician-fee-schedule/ or the specific payer

Table 4 – Ini	itial Preventive Physical Exams	
HCPCS Codes	Evaluation and Management Codes	Medicare Physician Fee Reimbursement Amount
G0402	wentative Physical Exam (IPPE) Medicare Welcome to Medicare visit billed only within the first twelve (12) months of membership; initial exam	\$167.33
Annual Wellness G0438	Visits (AWV) Medicare Occurs twelve (12) months after initial membership; welcome to Medicare visit; initial exam	\$172.34
G0439	Subsequent AWV visits; permitted once every twelve (12) years	\$116.56

Table 5 – Pr	evention/Risk Reduction Codes	
CPT Codes	Evaluation and Management Codes	Calculations Based on a Medicare Physician Fee Reimbursement Amount
Patient Visits		
99401 - 99404	Preventative medicine/risk reduction	\$36.47 - \$112.27

Note: These codes are to report services provided at a separate encounter. These codes are not appropriate to use with CPT codes 99381-99397. Medicare for Part B payment no longer recognizes CPT codes 99241-99245 however, some commercial insurance carriers will support reimbursement. Consult with specific payer for more information.

Table 6 – Of	fice Consultation	
CPT Codes	Evaluation and Management Codes	Calculations Based on a Medicare Physician Fee Reimbursement Amount
Patient Visits		
99241 - 99245	Office consultation for a new or established patient	\$48.98 - \$227.04

Note: Medicare for Part B payment no longer recognizes CPT codes 99241-99245. However, telehealth consultation codes (Healthcare Common Procedure Coding System G0406-G0408 and G0425-G0427) continue to be recognized for Medicare payment. Consult with your local MAC for more information.

Sample CMS-1500 Claim Form for OraQuick[®]

Physician Patient Services Delivered in an Office Setting

EALTH INSURANCE CLAIM FORM	A R R F
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12	
MEDICARE MEDICAID TRICARE CHAMPVA GROUP FECA	OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) (Medicaid#) (ID#/DoD#) (MemberID#) (ID#) (ID#) <td< th=""><th>(<i>ID#</i>) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th></td<>	(<i>ID#</i>) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	F
Inter all applicable ICD-9/ICD-10 codes.	
II HCV high-risk claims must be	
ccompanied by ICD-9 diagnosis code	ZIP CODE TELEPHONE (Include Area Code)
69.8 [Z72.89 once ICD-10 is implemented].	CITY STATE
creening may occur on an annual basis	a. INSURED'S DATE OF BIRTH SEX
appropriate as defined in the policy $r = r$	Block 24, Column E
e.g. cont'd Intravenous Drug Use with $r_{r_2}^{s}$	For each HCPCS/CPT code,
egative initial screen result] (See Table 2).	For each HCPCS/CPT code, insert the letter corresponding to
(Designated by N	the appropriate diagnosis code
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S GIGNATURE I authorize the release of any medical or other informatio to process this claim. I also request paymed for government benefits either to myself or to the party who accepts assis.	entered in Block 21.
below.	
SIGNED	SIGNED 16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION 16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD VY
NAME OF REFERRING PROVIDER OR OTHER SOURCE 178.	FROM DU YY TO MM DU YY 18. HOSPIJALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DU YY
17b. NPI	FROM
ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22 AESUBMISSION CODE ORIGINAL REF. NO.
F G н	Block 24, Column D
L K, L L A. DATE(S) OF SERVICE B. C. D. PROCEDURES, SERVICES, OR SUPPLIES From To PIACE OF (Explain Unusual Circumstances) D	E Include the modifier QW when
M DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER F	describing the OraQuick [®] HCV
4 15 15 04 15 15 11 🖌 G0472 QW 🔶 🖊	BC test in conjunction with the
4 15 15 04 15 15 11 🖌 99XXX 🛛 🗸	ABC G0472 (See Table 1).
	G0472 (See Table 1).
Block 24, Column D	
Enter the appropriate HCPCS/CPT codes along	
with appropriate modifiers:	
• C0/72 OW/ describes the test (See Table 1)	MENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use
• 99XXX - describes E & M service (See Tables 3-6)	D \$ \$
Note: Prevention/Risk Reduction and E&M codes	33. BILLING PROVIDER INFO & PH # ()
are rarely submitted together. Consult your local	
-	

OraSure does not guarantee that this information is a complete listing of appropriate codes and reminds you that these policies change frequently.

This information provided inside is for illustrative purposes only. It does not represent a summary of the laws, regulations or payer policies concerning reimbursement in your area.

Medicare payment rate information is provided as a benchmark of what MAY be paid by various payers in your area. Actual payment will vary by payer type, geographic location, and other factors. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. While OraSure recommends that you consult the specific payer for any questions that may arise, we are pleased to offer you additional assistance. **Please feel free to contact us at 1-844-837-8437 if you need additional assistance.**



OraSure Technologies

220 East First Street Bethlehem, PA 18015 1-844-TestHepC (1-844-837-8437) www.TestHepC.com Because private payer coverage policies and benefit plans differ greatly, the information offered in this guide may not be applicable for billing and reporting to private payers. The treating provider is responsible for determining the medical necessity for each specific patient case. Claims submitted to payers should reflect the medical decisions made by the treating provider, current applicable state and federal regulations, and the provisions of the patient benefit plan. Current Procedural Terminology (CPT) codes and descriptions are copyright ©2015 American Medical Association (AMA). All Rights Reserved. CPT is a trademark of the AMA.