

Screening for the Human Immunodeficiency Virus (HIV) Infection (NCD 210.7)

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[↪ Terms and Conditions](#)

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<p>Related Medicare Advantage Reimbursement Policy</p> <ul style="list-style-type: none"> Laboratory Services Policy, Professional
<p>Related Medicare Advantage Coverage Summary</p> <ul style="list-style-type: none"> Preventive Health Services and Procedures

Policy Summary

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Overview

Human Immunodeficiency Virus (HIV) is an infection caused by a retrovirus that affects the immune system. HIV infection causes acquired immune deficiency syndrome (AIDS), a disease which severely compromises an individual’s immune system. It is currently generally accepted that antiretroviral therapy (ART) has significantly reduced HIV-associated morbidity and mortality throughout the world and the United States, and has transformed HIV disease for many, into a chronic, manageable condition. There is also evidence that the use of ART is associated with a substantially decreased risk for transmission of the virus to uninfected persons.

The Centers for Medicare & Medicaid Services (CMS) is allowed to add coverage of “additional preventive services” through the national coverage determination (NCD) process if certain statutory requirements are met. One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF).

The USPSTF gives a Grade A recommendation to screening for HIV in:

- All adolescents and adults between the ages of 15 to 65 years,
- Younger adolescents and older adults who are at increased risk of HIV infection, and,
- All pregnant women.

Guidelines

Nationally Covered Indications

Effective for claims with dates of service on and after April 13, 2015, CMS has determined that the evidence is adequate to conclude that screening for HIV infection for all individuals between the ages of 15 and 65 years, as recommended with a Grade of A by the USPSTF, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS shall cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point of care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary’s physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider or supplier for these services, for beneficiaries who meet one of the following conditions:

- Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual voluntary screening for all adolescents and adults between the age of 15 and 65, without regard to perceived risk.
- Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:
 - Men who have sex with men
 - Men and women having unprotected vaginal or anal intercourse
 - Past or present injection drug users
 - Men and women who exchange sex for money or drugs, or have sex partners who do
 - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
 - Persons who have acquired or request testing for other sexually transmitted infectious diseases
 - Persons with a history of blood transfusions between 1978 and 1985
 - Persons who request an HIV test despite reporting no individual risk factors
 - Persons with new sexual partners
 - Persons who based on individualized physician interview and examination are deemed to be at increased risk for HIV infection. The determination of “increased risk” for HIV infection is identified by the health care practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical recommendation should be a reflection of the service provided.
- A maximum of three, voluntary HIV screenings of pregnant Medicare beneficiaries: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman’s clinician.

Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 13, 2015:

- Medicare beneficiaries with any known diagnosis of a HIV-related illness are not eligible for this screening test.
- Medicare beneficiaries between the ages of 15 and 65 who have had a prior HIV screening test within one year are not eligible for HIV screening (i.e., at least 11 full months must have elapsed following the month in which the previous test was performed in order for the subsequent test to be covered).
- Medicare beneficiaries younger than 15 or older than 65, at increased risk for HIV-related illnesses, who have had a prior HIV screening test within 1 year are not eligible for HIV screening (i.e., at least 11 full months must have elapsed following the month in which the previous test was performed in order for the subsequent test to be covered).
- Pregnant Medicare beneficiaries who have had three specified screening tests within each respective term of pregnancy are not eligible for further HIV screening during their pregnancy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
80081	Obstetric panel (includes HIV testing)

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HCPCS Code	Description
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 assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening
G0475	HIV antigen/antibody, combination assay, screening

Place of Service Code	Description
11	Office (Physician claims)
81	Independent laboratory (Physician claims)

References

CMS National Coverage Determinations (NCDs)

[NCD 210.7 Screening for the Human Immunodeficiency Virus \(HIV\) Infection](#)

Reference NCDs: [NCD 190.13 Human Immunodeficiency Virus \(HIV\) Testing \(Prognosis Including Monitoring\)](#), [NCD 190.14 Human Immunodeficiency Virus \(HIV\) Testing \(Diagnosis\)](#)

CMS Benefit Policy Manual

[Chapter 15: § 80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, § 80.1 Clinical Laboratory Services](#)

CMS Claims Processing Manual

[Chapter 16: § 40 Billing for Clinical Laboratory Tests](#)

[Chapter 18: § 1.2 Table of Preventive and Screening Services, § 130 Human Immunodeficiency Virus \(HIV\) Screening Tests](#)

CMS Transmittal(s)

[Transmittal 3461, Change Request 9403, Dated 02/05/2016 \(Screening for the Human Immunodeficiency Virus \(HIV\) Infection\)](#)

[Transmittal 3766, Change Request 9980, Dated 05/05/2017 \(Screening for the Human Immunodeficiency Virus \(HIV\) Infection\)](#)

[Transmittal 3778, Change Request 9980, Dated 05/24/2017 \(Screening for the Human Immunodeficiency Virus \(HIV\) Infection\)](#)

[Transmittal 3835, Change Request 9980, Dated 08/16/2017 \(Screening for the Human Immunodeficiency Virus \(HIV\) Infection\)](#)

MLN Matters

[Article MM9403, Screening for the Human Immunodeficiency Virus \(HIV\) Infection](#)

[Article MM9980, Screening for the Human Immunodeficiency Virus \(HIV\) Infection](#)

Other(s)

[CMS Medicare Preventative Services, ICN 006559 March 2019](#)

[CMS Preventative Services Announcement 2015-06-18 Medicare Provides Coverage of HIV Screening, National HIV Testing Day](#)

[Decision Memorandum for Screening for Human Immunodeficiency Virus \(HIV\) Infection, Dated 04/13/2015, CMS Website](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
06/10/2020	Policy Summary <i>Overview</i> <ul style="list-style-type: none">Removed reference to <i>Section 101(a) of the Medicare Improvements for Patients and Providers Act</i> Applicable Codes <ul style="list-style-type: none">Removed place of service codes 19, 20, 22, 23, 24, 25, 49, 57, and 65 Supporting Information <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current informationArchived previous policy version MPG277.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare

Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT[®]), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT[®] or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).