
Billing and Coding for HIV Care
PRIMARY CARE
DEVELOPMENT
CORPORATION

Facilitating and Presenting

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PrimaryCareDevelopmentCorp @PrimaryCareDev

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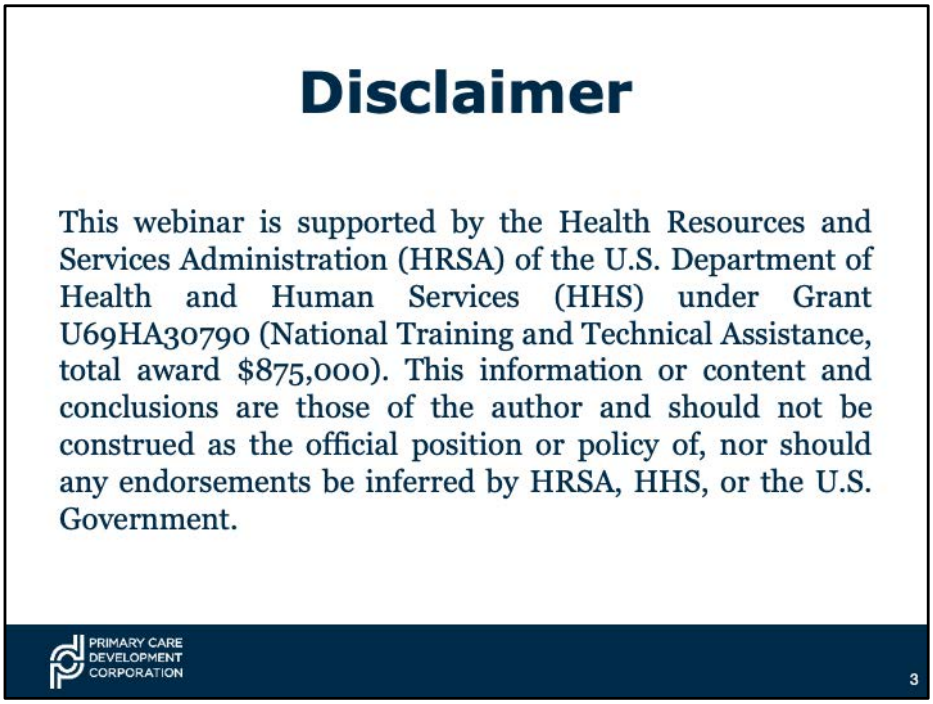

Please read slide verbatim.

About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

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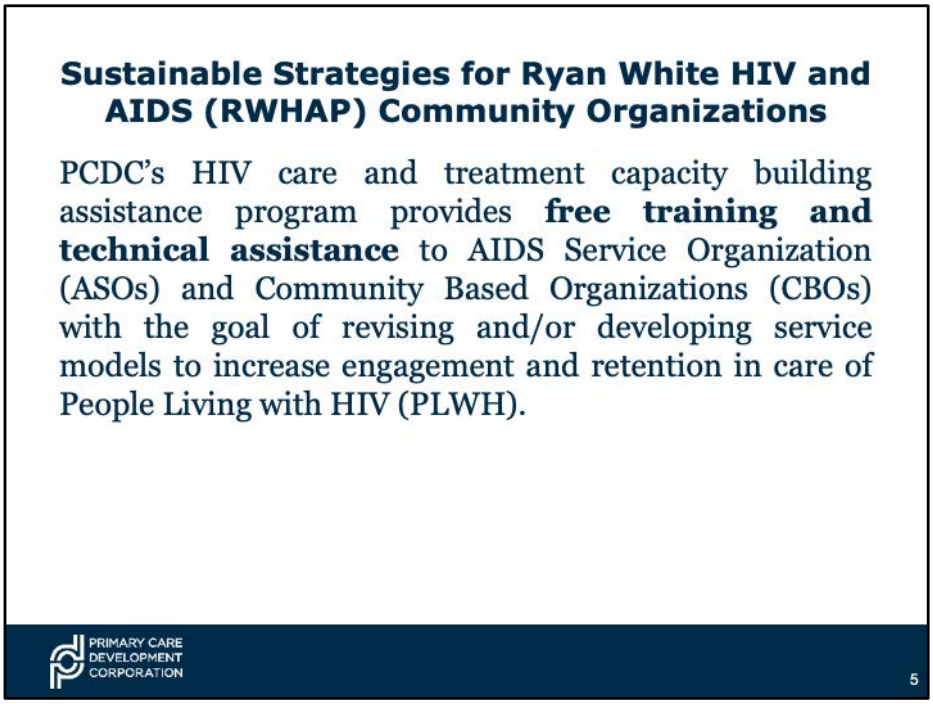


Please do not read slide – speaker notes only: Through PCDC's Sustainable Strategies for Ryan White HIV Program Community Organizations, we provide free training and technical assistance to RWHAP-funded ASOs and CBOs to increase their capacity to improve engagement and retention of PLWH in care by enhancing service models or partnering with service providers in the health care system.

This is a 3 year, HRSA-HAB funded, cooperative agreement under the Division of Policy and Data (DPD), Evaluation Analysis and Dissemination Branch. Our Program Officer is Michael Evanson.

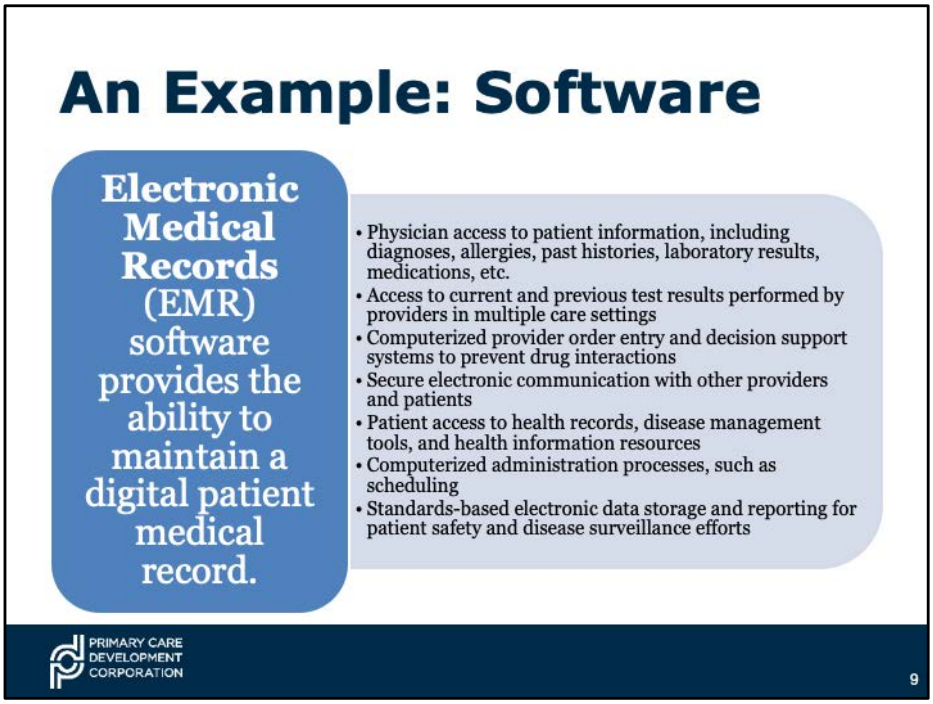
Follow up Office Hour!

- Looking for:
  - a deeper dive?
  - individual level support?
  - further discussion on billing & coding?
- Join us for a drop-in "office" hour with the expert from today's webinar
- Monday, March 2 at 2:00 E/1:00 C/12:00 M/11:00 P
- Registration link (https://pcdc.zoom.us/webinar/register/WN_YBrAOGwYTH29Iw4yac3zAA) will be included in the post-webinar email

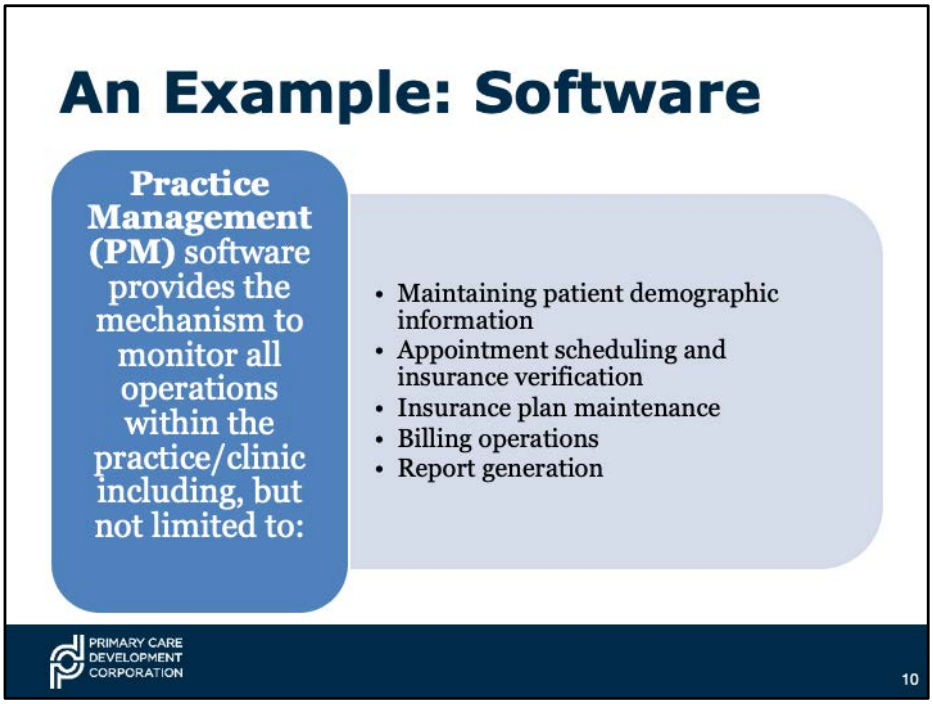
Learning Objectives

- Intro to Billing and Coding for Primary Care Services
- HIV Care Considerations
- Screening for Other STIs
- The Billing and Coding Team
- Carrier Contracting
- Provider Credentialing
- Reimbursement for PrEP and PEP

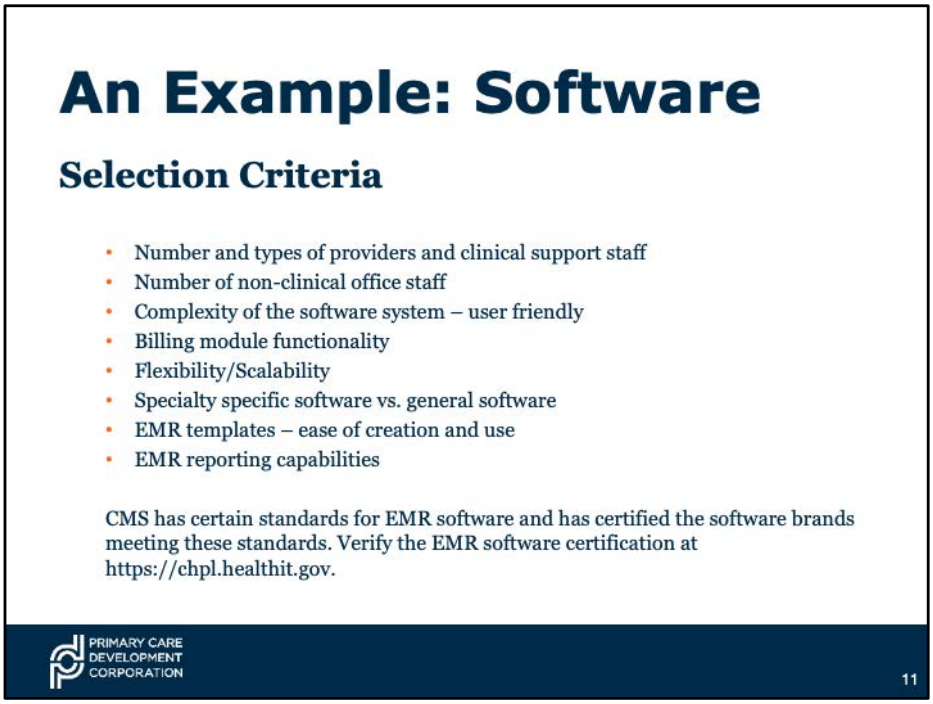
When thinking about sustainability it's important to remember that proper billing & coding is crucial to maximizing your organization's reimbursement, avoiding missed revenue opportunities, and ensuring the continual provision of services. Whether your organization is currently exploring setting up a billing team or may already have years of experience, today's presentation contains information that will help you develop your organization's long-term fiscal sustainability. However, there are potential pitfalls that can hinder your organization's ability to utilize the knowledge you'll learn today. Conversely, these same variables can enable your organization to vastly improve its billing & coding services when done correctly.



A pertinent example of this is software. Selecting and utilizing electronic medical records, EMRs, and practice management software is absolutely vital to the billing process and improving the overall quality of your services. Both administrative and clinical duties are streamlined ensuring safety and efficiency.



The practice management software not only includes your scheduling tools, which govern how you organize your patient appointments and keep track of which providers are booked at what times, but most importantly for our purposes, it also helps your staff manage the billing cycle.



When purchasing or updating software think about criteria that are listed here as well as other criteria that are important to your individual organization. Perform research and attend software demonstrations to better understand your options. EMR reporting capabilities is especially important to partake in value-based healthcare incentive and quality programs. Make sure the reporting capability meets your needs. CMS has certain standards for EMR software and has certified the software brand that meet these standards. During today's webinar you'll learn about other aspects of billing, such as contracting and credentialing, that can be barriers to maximizing your organization's billing potential if not done correctly. We encourage each one you when you leave here today to think about what may be organizations billing operations and how that can be improved.

Intro to Billing and Coding for Primary Care

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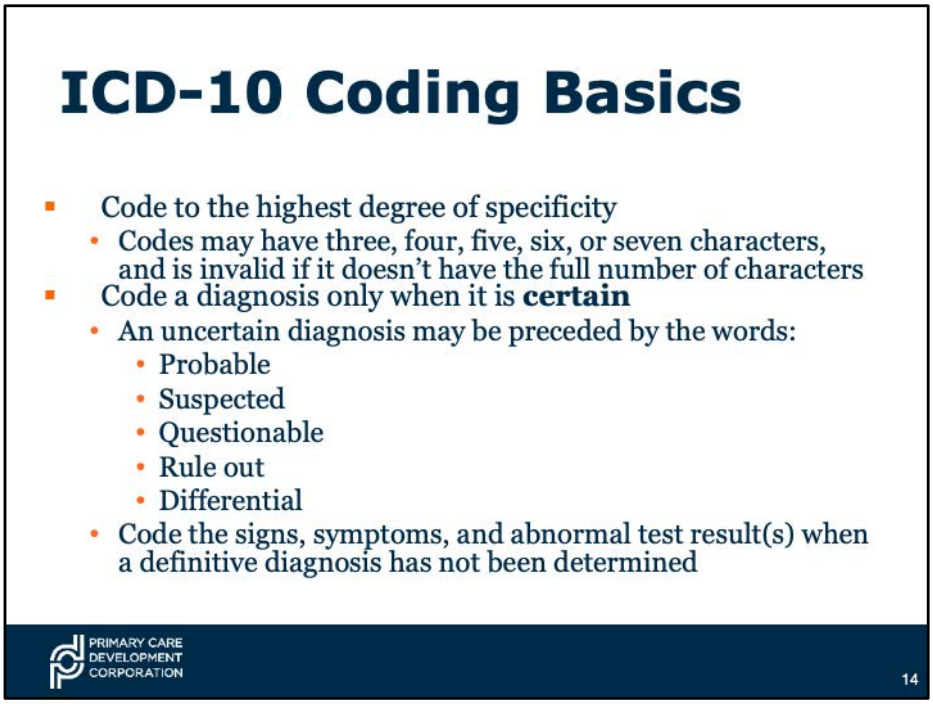
ICD-10 Codes

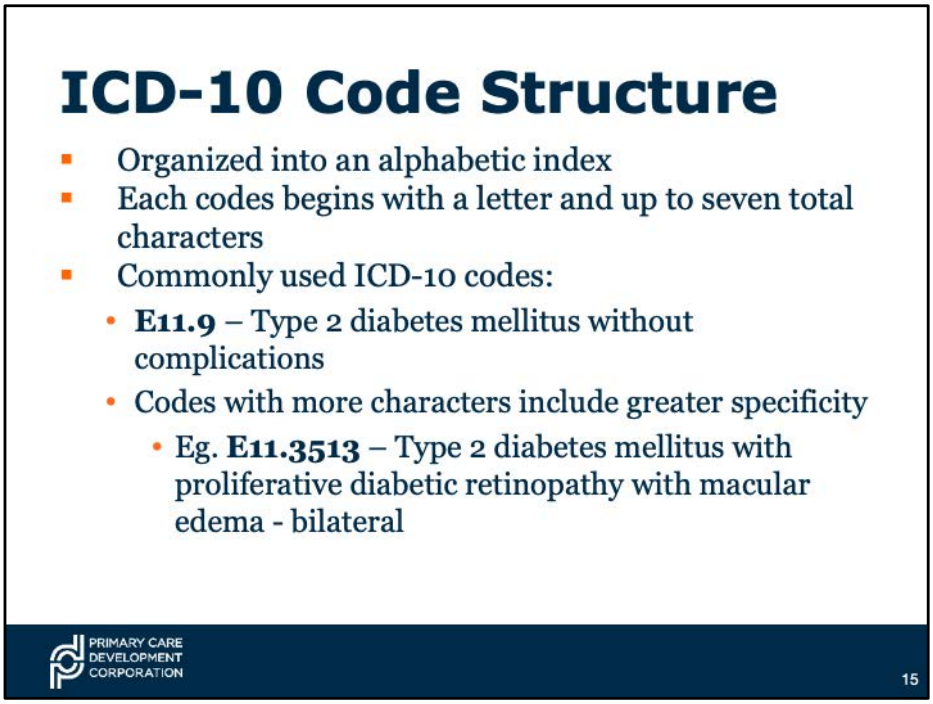
- ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used to classify diseases and other health problems, including symptoms, injuries, and diseases
- First versions of disease classifications developed in 1850s
- Used by the World Health Assembly and the World Health Organization (WHO)

https://searchhealthit.techtarget.com/definition/Current-Procedural-Terminology-CPT

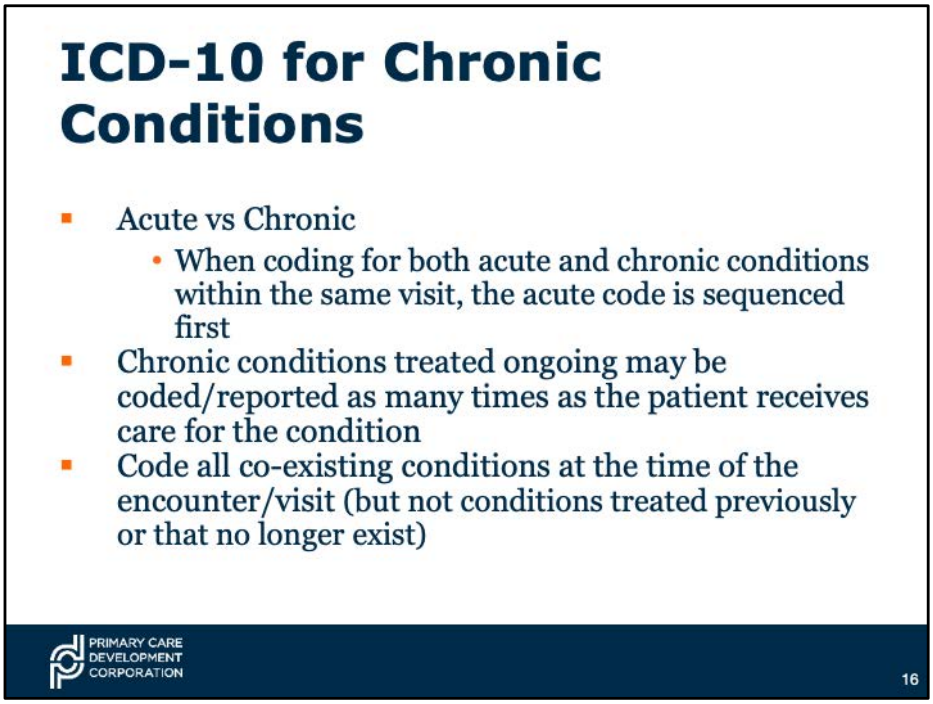


Specificity:
Describe each condition to the highest level of specificity:
Consider:

- With or without exacerbation
- With or without complications
- Acute versus chronic
- Severity – mild, moderate, severe
- Stages or types
- Controlled or uncontrolled
- Underlying case
- Location or site, including laterality, specific site within a body type (upper outer quadrant, lower inner quadrant, etc)



7th character '3' denotes bilateral



Can code 4 conditions for CPT code

ICD-10 – Identifying the Episode of Care

- 7th character added at the end of an ICD-10 code to identify the episode of care
- A – Initial Encounter
  - Initial visit (for treatment or active care) of a new illness, injury or condition
  - May be used more than once by the same provider if active care is still being provided such as surgical treatment, emergency department encounter, and evaluation and treatment by a new physician

https://www.aapc.com/blog/27096-initial-subsequent-sequela-encounter/

ICD-10 – Identifying the Episode of Care

- D – Subsequent Encounter
  - Encounters after patient has received active treatment for an injury or illness and is receiving routine treatment during healing/recovery phase
  - No limit on the number of times code can be used

https://www.aapc.com/blog/27096-initial-subsequent-sequela-encounter/

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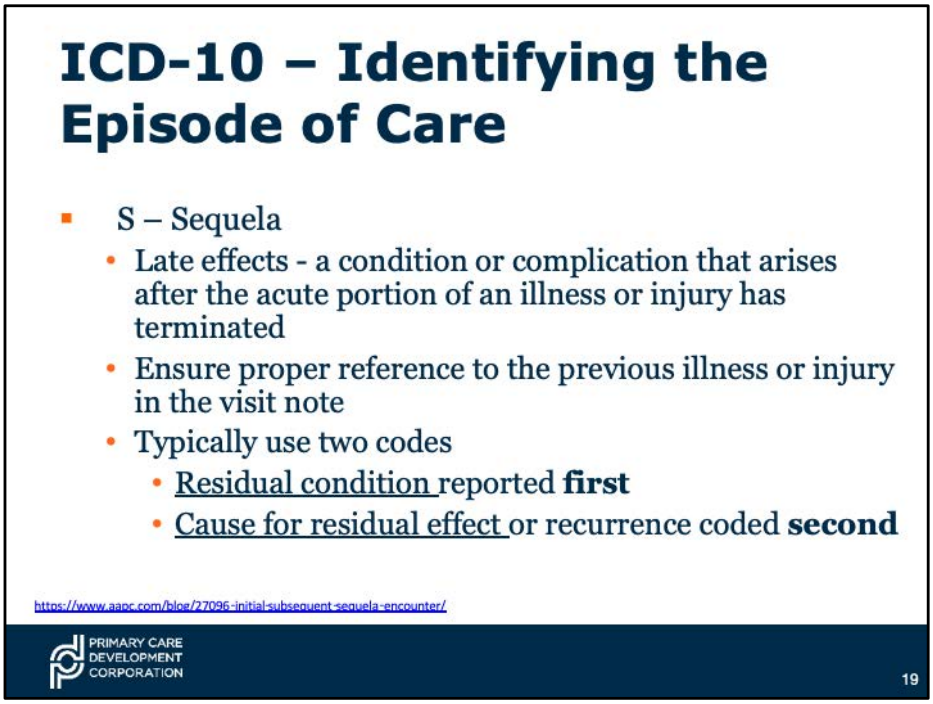
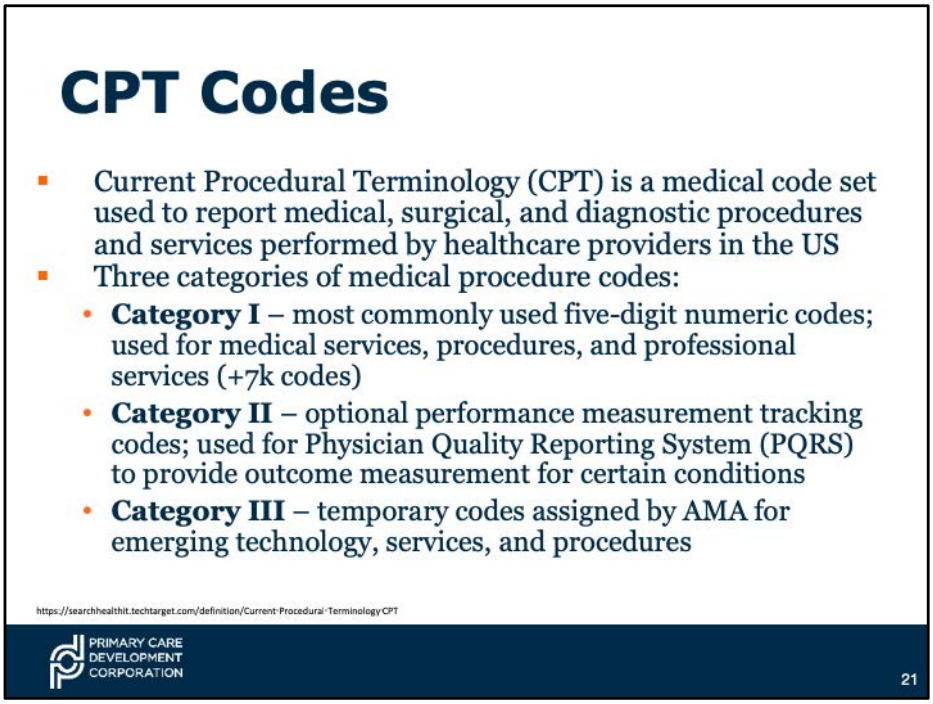


Example scar as sequela of a burn

Perhaps the most common sequela is pain. Many patients receive treatment long after an injury has healed as a result of pain. Some patients might never have been treated for the injury at all. As time passes, the pain becomes intolerable and the patient seeks a pain remedy.

ICD-10 Coding Considerations

- General Medical Examinations with Abnormal Findings – report **Z00.1** as primary code
  - Report abnormal findings as additional codes
  - "An examination that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination."

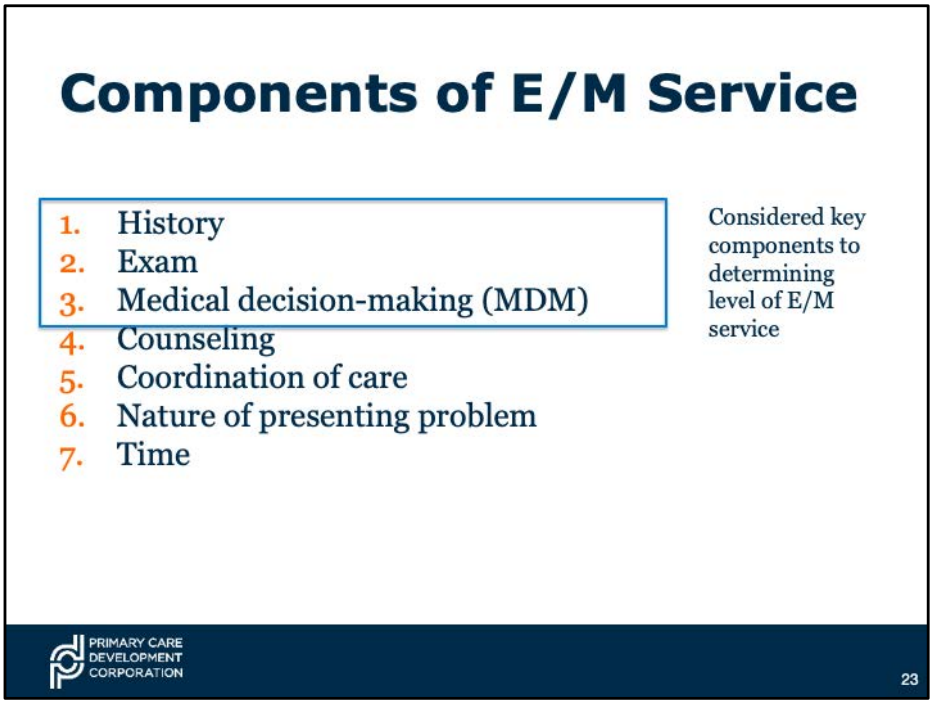


Category 1 – updated annually by the AMA
Category 2 – PQRS is an incentive-based program developed by CMS to record evidence-based measures. Located in the back of the CPT book. Alphanumeric codes with a letter "F" in the last positions (Statin Therapy 4013F). Reported in addition to E/M services or clinical CPT1 codes

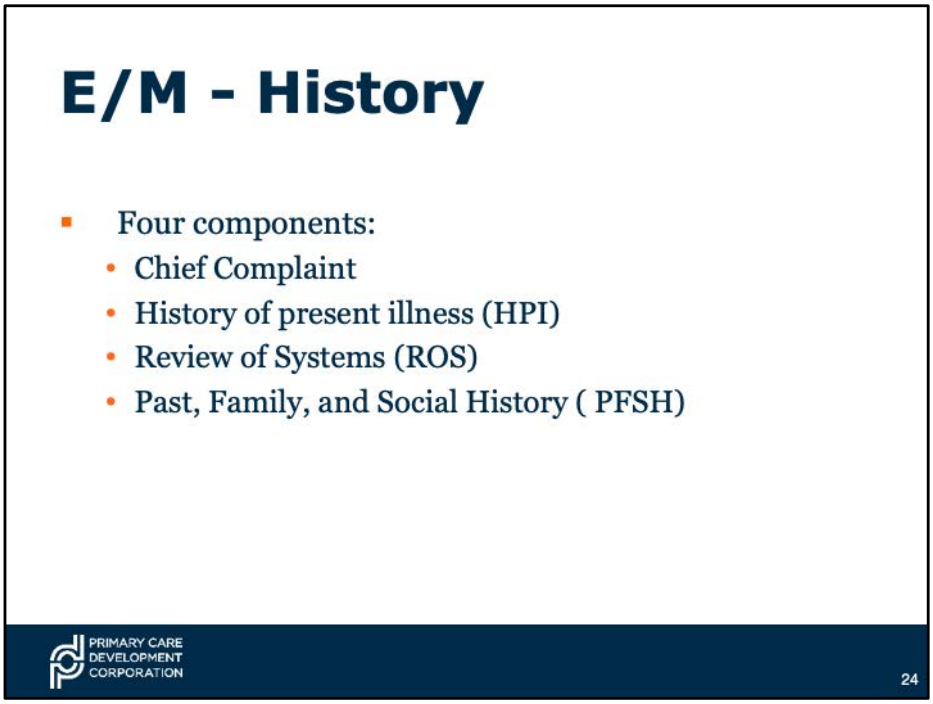
Insurance companies pay for services that are described by a CPT® code and performed by a licensed practitioner or for work performed under the supervision of a licensed practitioner. Services are paid based on a fee associated with each CPT® code. In some instances, a set of services will be reimbursed 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.

Evaluation and Management Coding

- Describe a provider's service to a patient including evaluating the patient's condition(s) and determining the management of care required to treat the patient
- Most common CPT codes used by primary care providers
- May also include services based only on the time spent with the patient



First three components must be included in the documentation of the patient encounter



If no chief complaint is documented, the service is considered preventive and reported using preventive service code

E/M - Exam

- Exam
  - Must be performed by provider, not ancillary staff
  - Avoid using language such as 'unremarkable' and 'non-contributory' or 'negative' or 'normal'
- Scored as follows:
  - Problem-Focused: 1-5 elements identified by a bullet.
  - Expanded Problem-Focused: At least 6 elements identified by a bullet.
  - Detailed: 9/12 bullets must be properly documented, and the affected area/system is examined in detail.
  - Comprehensive: Documentation of all areas identified by a bullet in the

Examination				
Body Areas: • Head, including face, neck, abdomen, genitalia, groin, buttocks • Chest, including breast and axilla, each extremity, back, including spine Organ Systems: • Constitutional Respiratory Musculoskeletal Psychiatric • Cardiovascular GI Skin Hem/Lymph/Imm • ENMT, GU Neurological Eyes	1 body area or organ system	2-7 systems – limited exam	2-7 systems – detailed exam	8 or more systems
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

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E/M – Medical Decision Making

- Diagnoses being treated
  - The level of risk MUST be assigned to each encounter as it mirrors the medical necessity of the documentation.
- The level of risk is broken down into 3 categories:
  1. Presenting Problem
  2. Diagnostic Procedure
  3. Management Options
     - The highest level selected, within the above three areas, indicates the level of risk.

Medical Necessity

- Justification of care provided based on:
  - Knowledge of the emergent nature or severity of patient's complaint or condition
  - All signs, symptoms, complaints or background facts describing the reason for care

E/M – The Whole Picture

History	Exam	Medical Decision Making
• Chief Complaint • History of Present Illness (HPI) • Review of Systems (ROS) • Past, Family, Social History (PFSH)	• Constitutional • Eyes • Ears, Nose, Throat, Mouth • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary • Musculoskeletal • Skin • Neurological • Psychiatric • Hematologic/lymphatic/ immunologic	• Number of diagnosis and management options • Amount and complexity of data to be reviewed • Level of risk

An Example

Established patient office visit table				
HISTORY	Problem focused	Expanded problem focused	Detailed	Comprehensive
EXAM	Problem focused	Expanded problem focused	Detailed	Comprehensive
MEDICAL DECISION MAKING	Straightforward	Low	Moderate	High
LEVEL OF VISIT	99212	99213	99214	99215

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Modifiers

- Added to CPT and HCPCS Level II codes to report specific circumstances or alterations to a procedure, service, or medical equipment
- When applicable, modifiers should be reported immediately after the code
- Modifiers frequently used for E/M services:
  - Modifier 50 – service performed bilaterally
  - Modifier 76 –exact same service repeated by the same physician or another physician of the same specialty and same group practice.

HIV Care Considerations

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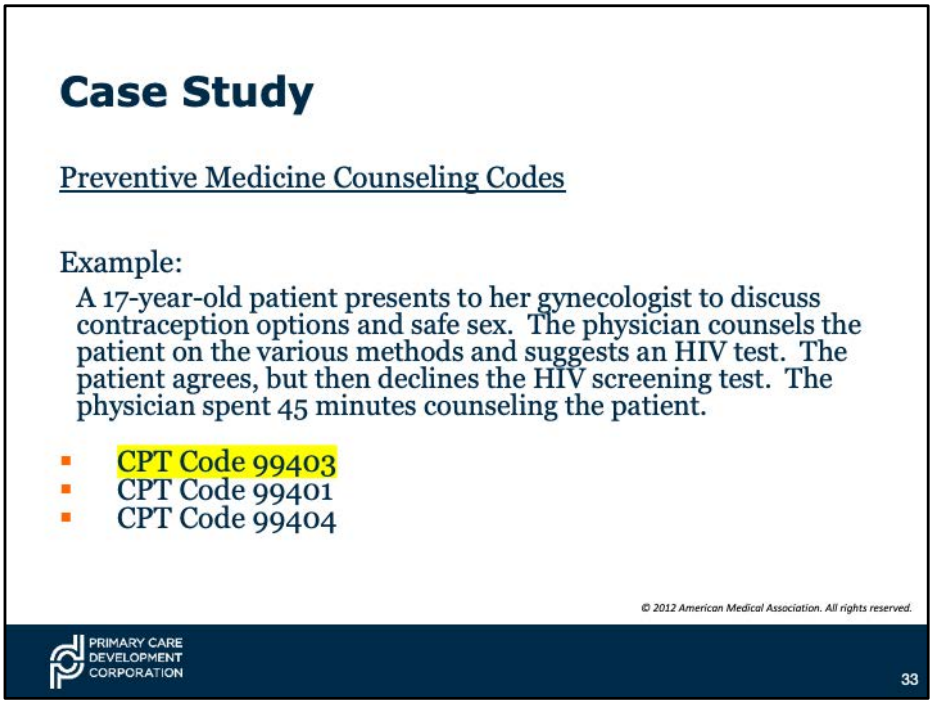
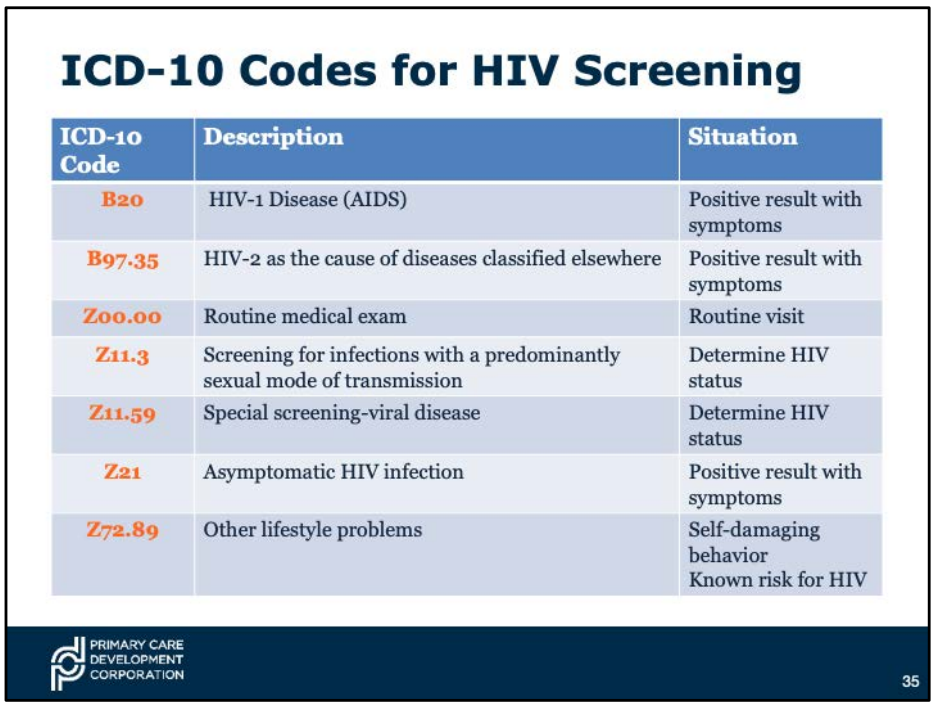


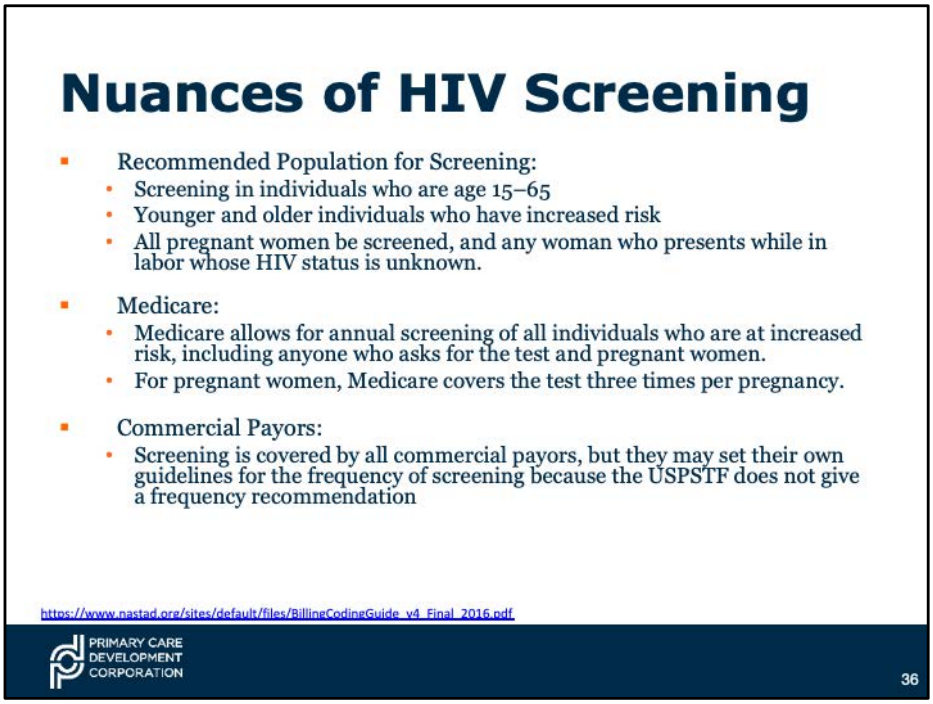
Remember: Because 99401-99404 are time-based, your physician must document the amount of face-to-face time spent counseling, and the content of the counseling is crucial. Notes for the counseling visit should include references to pamphlets or other materials the physician reviewed with the patient

HIV 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 infections with a predominantly sexual mode of transmission	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 use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and the service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.



United States Preventive Services Task Force (USPSTF)

HIV Screening in a Non-Primary Care Setting

- 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.1
  - Modifier 33 was not appended to the CPT® or HCPCS code.

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

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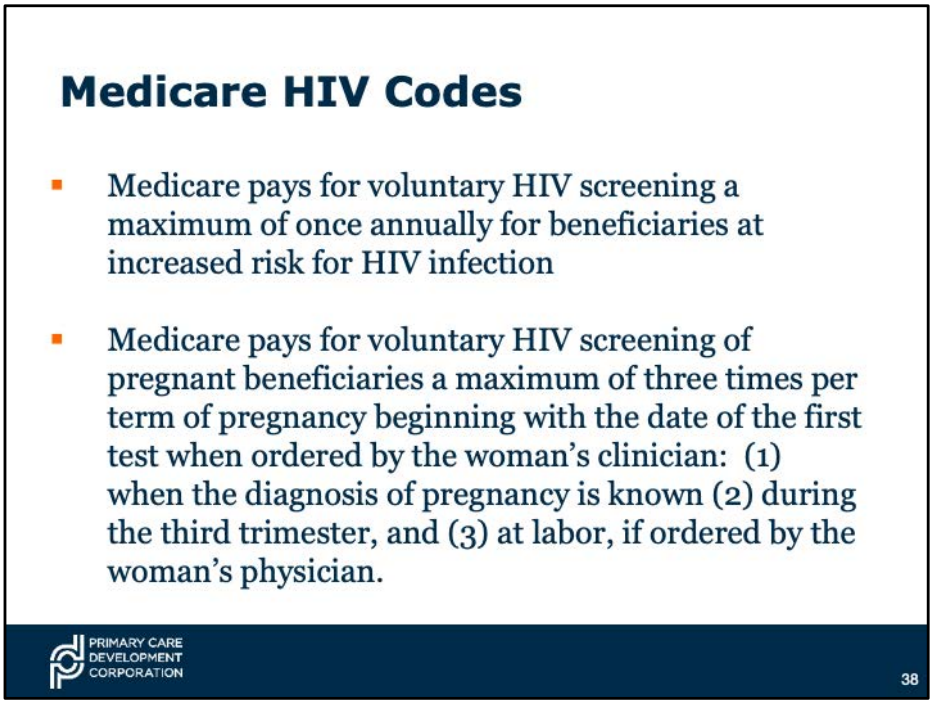
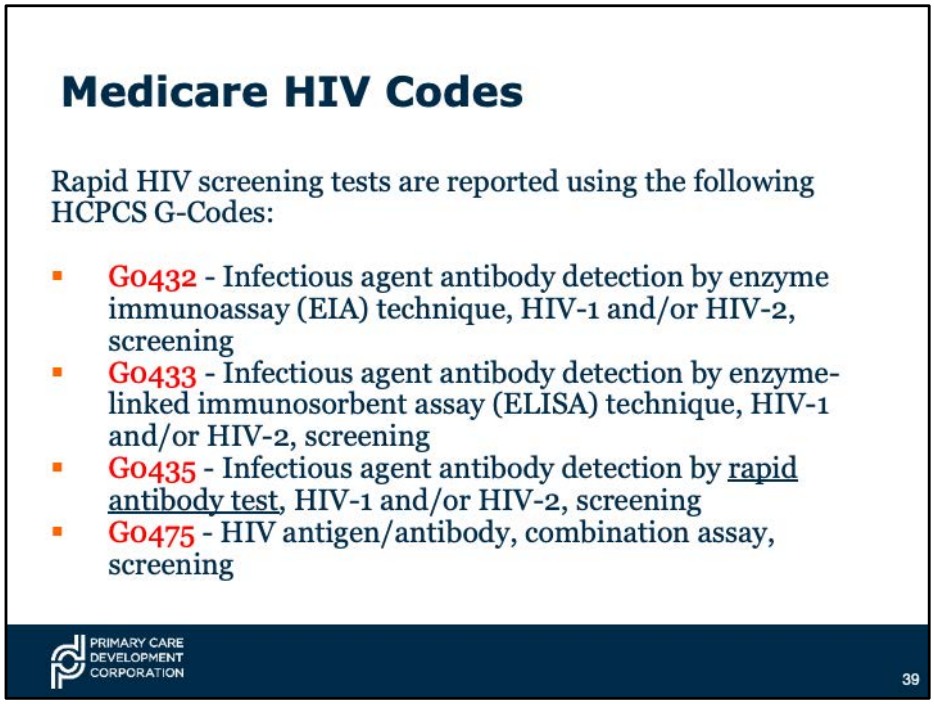
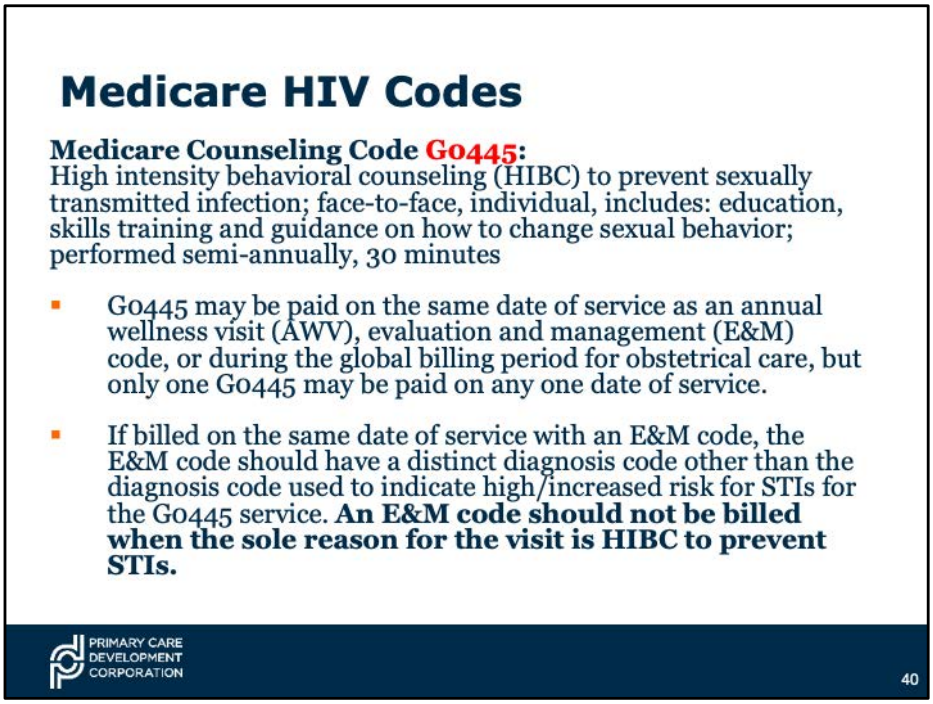


Rapid HIV tests give you results in about 20 minutes. Other tests take longer because they need to be sent out to a lab.



You can either get an “anonymous" or "confidential” HIV test, depending on the laws in the state. “Confidential" testing means your name is on the test, and the results go in your medical records. Doctors and insurance company may also see the results. If the test is positive, your results are sent to your local health department, so they know the rates of HIV in your area. But results are protected by privacy laws, so nobody else can see them without permission.

"Anonymous" testing means your name isn’t on the test. You get an ID number that is used to find out your results. Results won’t go in medical records, and they won’t be sent to an insurance company or the health department.



The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.

Lab Test for HIV and other STIs

- HIV screening has an 'A' rating form the USPSTF and is covered by Medicare, Medicaid and commercial insurance companies
  - No co-pay or deductible should be applied to a service with a USPSTF "A" or "B" rating.
- No specific screening intervals are suggested but there are recommendations

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

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Modifiers for HIV Screening

- **Modifier 33** – Preventive Service:
  - 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.
  - Use modifier 33 on the CPT code for HIV screening. This informs the payer that the service is a service recommended by the USPSTF.

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

Modifiers for HIV Screening

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

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

Screening for Other STIs

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Screening for Syphilis

- Recommendation:
  - One annual screening for syphilis in men and women at increased risk
  - Pregnant women, one screening per pregnancy and two additional screenings in the third trimester and at delivery if patient is at increased risk for STIs

CPT Code	Description
86592	2 Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-troponemal antibody; quantitative
86780	Treponema pallidum

Screening for Gonorrhea

- Recommendation:
  - One annual screening for gonorrhea women who are NOT at increased risk
  - Pregnant women, up to two screenings per pregnancy for patients at increased risk
  - Not enough data to recommend screening in men

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

- Recommendation:
  - Screening for at risk individuals, no frequency recommended
  - Pregnant women, screening recommended at the first visit
    - Medicare covers an additional screening at delivery for patients with increased risk

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

Screening for Chlamydia

- Recommendation:
  - One annual screening for women at increased risk
  - Pregnant women, up to two screenings per pregnancy for individuals at increased risk for STIs
  - Not enough information to recommend screening 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

Screening for Chlamydia

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

The Billing and Coding Team

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Who is Involved in Billing and Coding

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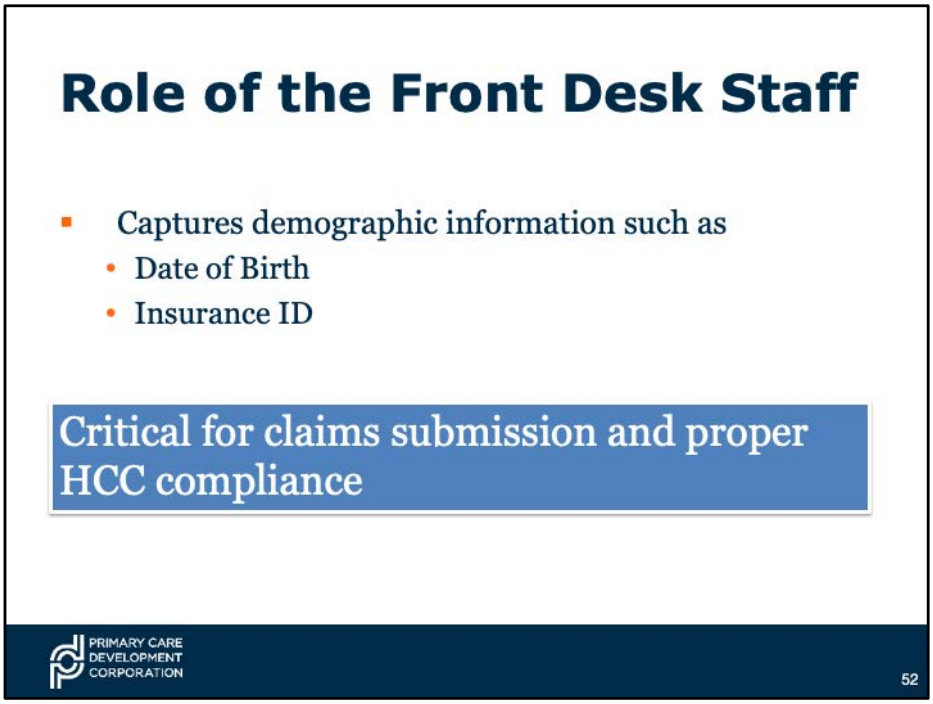


HCC- Hierarchical condition category – chronic conditions grouped into categories with predictive cost patterns, and then ranked based on predicted cost (risk). Based on ICD-10 codes submitted by practice

Role of the Medical Assistant (MA) and Nurse

- Typically initiates the patient encounter.
- Performs and documents a portion of the patient visits which may include:
  - Identifying the chief complaint
  - Review of the individual's medical and social history
  - Review of the individual's risk factors for depression or other mood disorders

Role of the Provider

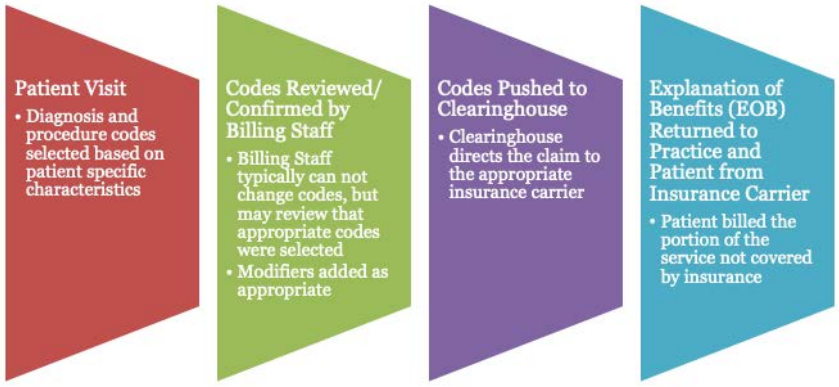
- Performs patient visit and documents encounter
- Selects appropriate **diagnosis code**, based on patient condition(s) and **procedure code**, based on length and complexity of the encounter

Role of Billing Staff

- Reviews and confirms that the correct diagnosis and procedure codes were selected by the provider
  - May involve reviewing and analyzing patient records

Billing and Coding staff can not change the codes selected for the visit. All changes to visit coding must be performed by billing provider

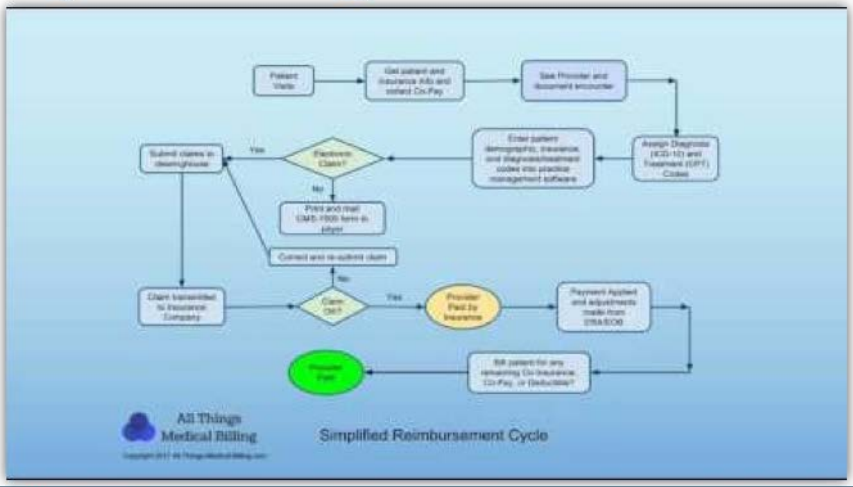
The Billing Process



Revenue Cycle Management

- Revenue cycle management is a process that helps organizations get paid the full amount for services as quickly as possible.
- Healthcare revenue cycle management is unique because bills and claims are usually processed over a long period of time. Oftentimes claims go back and forth between payers and providers for months until all issues have been resolved.
- Patients may not always have the funds available to immediately pay medical bills for anything not covered by insurance.

Basic Steps of Revenue Cycle Management



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Carrier Contracting

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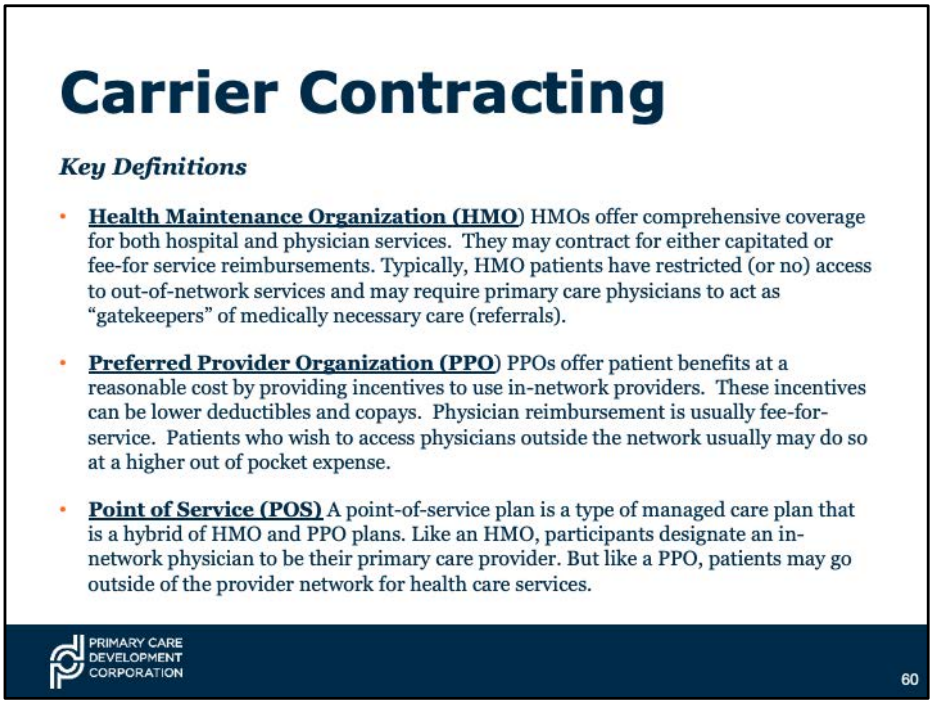
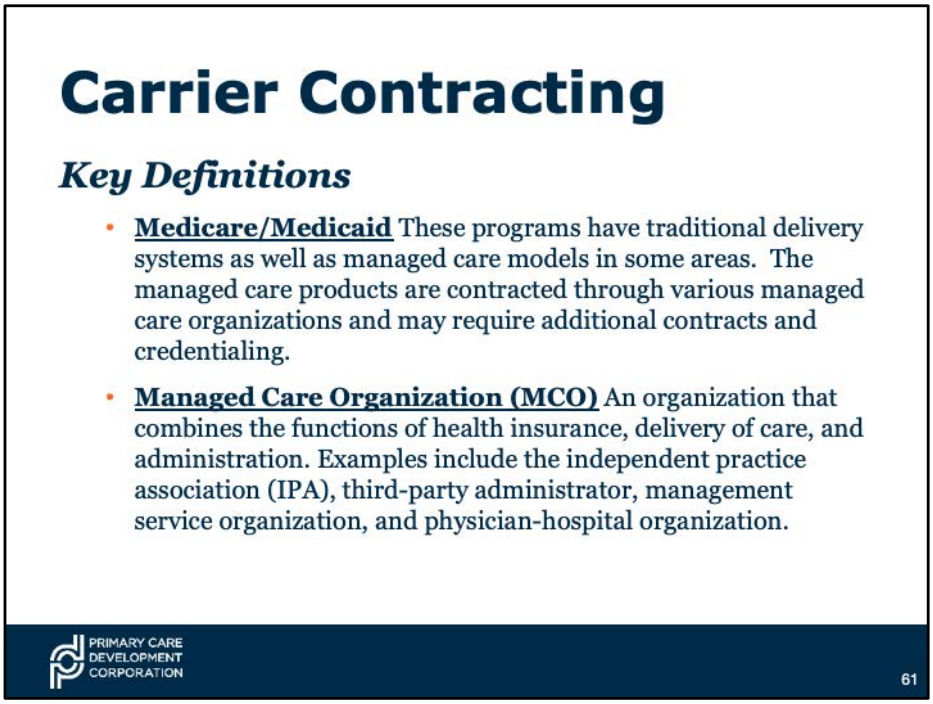
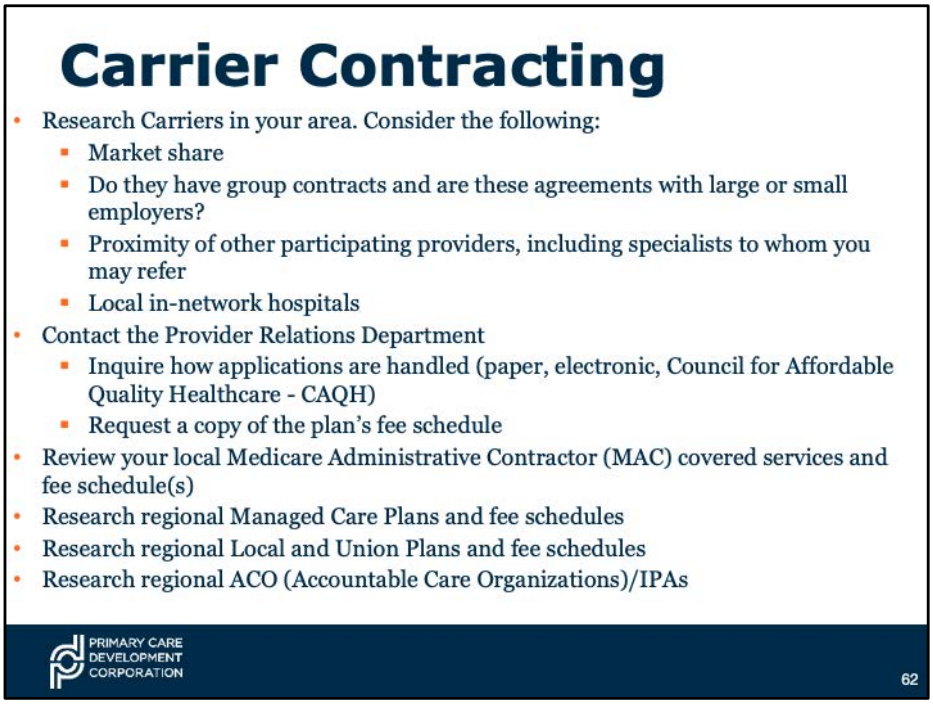


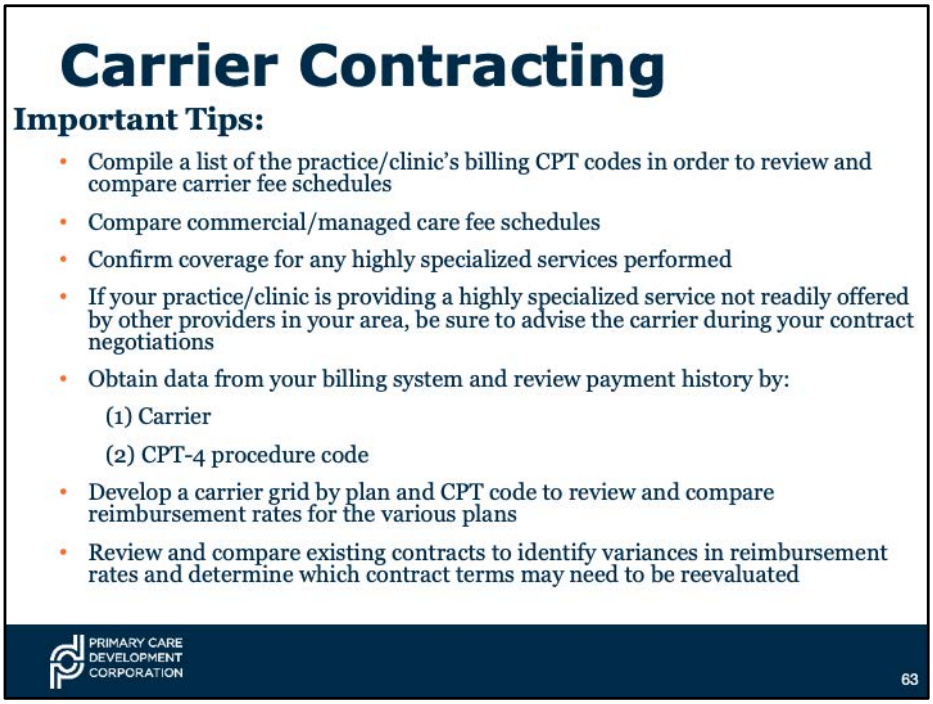
- Elaborate on the different types of current healthcare carrier models
- - Describe the differences between the types of plans allowing for a better understanding of how a plan affects office operations, (authorizations), carrier contracting, finances (deductibles) and other important factors



- Elaborate on the different types of Medicare/Medicaid plans
- Explain the federal government's incentive towards enrolling eligible beneficiaries in managed care programs



- Discuss how best to determine which carriers work best for each individual practice/clinic
- Evaluate the patient population the practice/clinic serves



-Review tips and best practices to initiate carrier contracting process

Provider Credentialing

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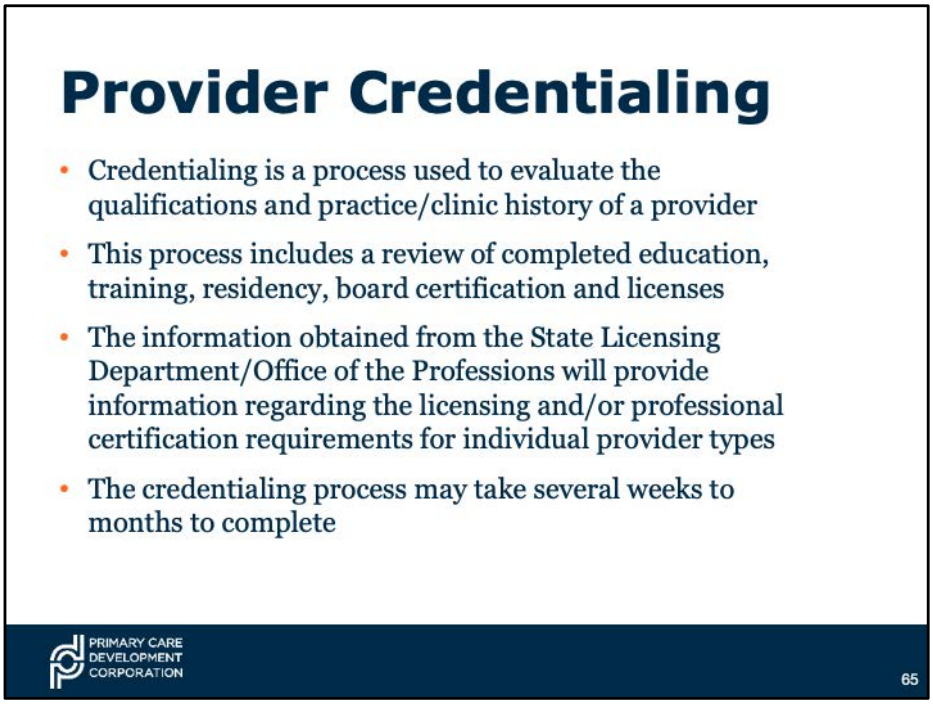
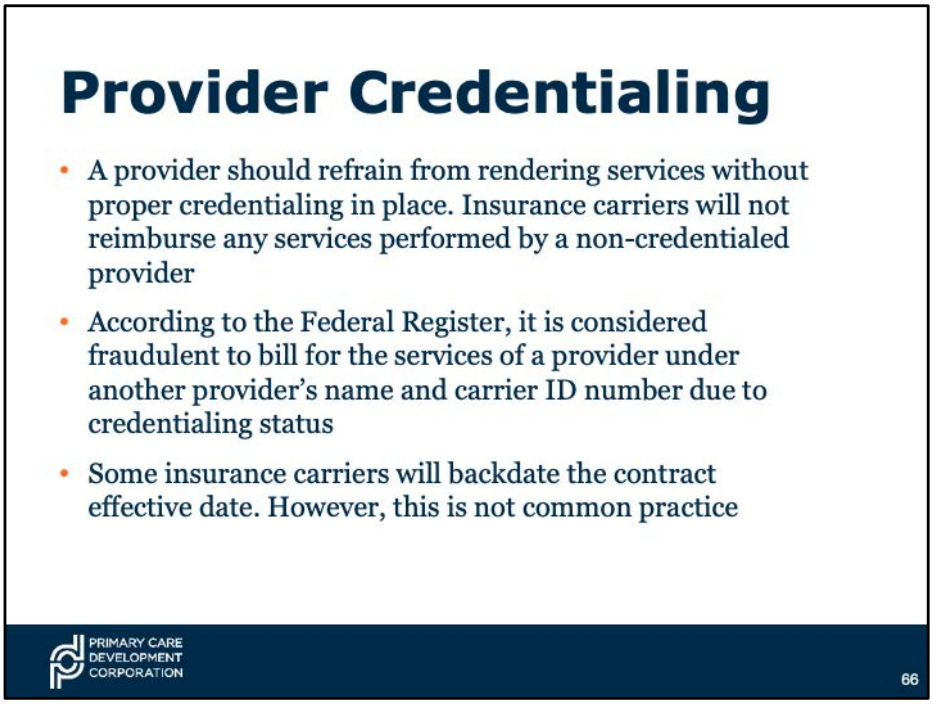
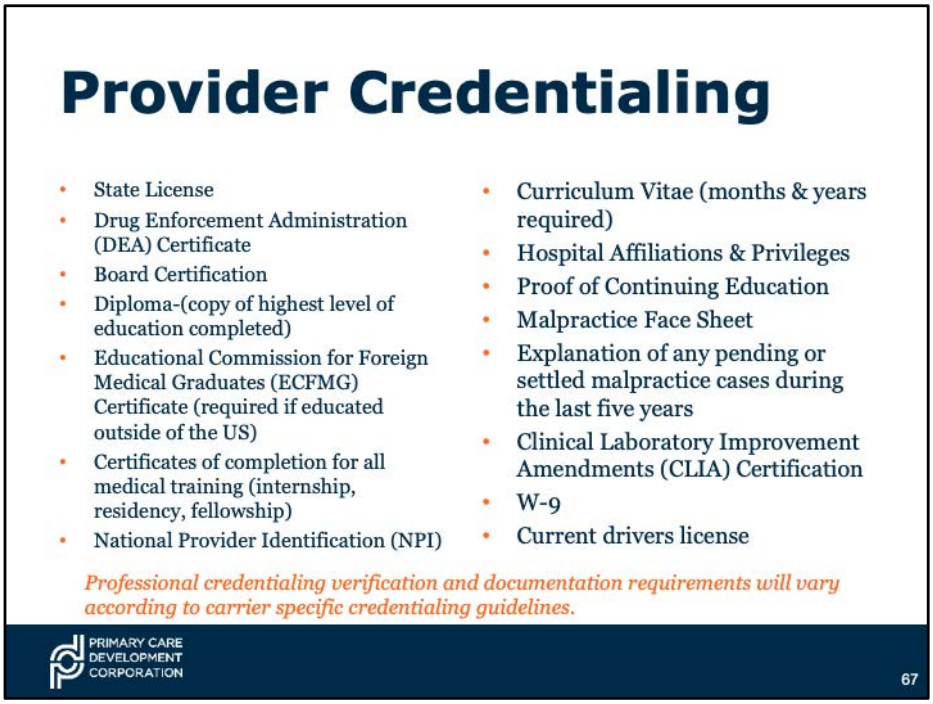


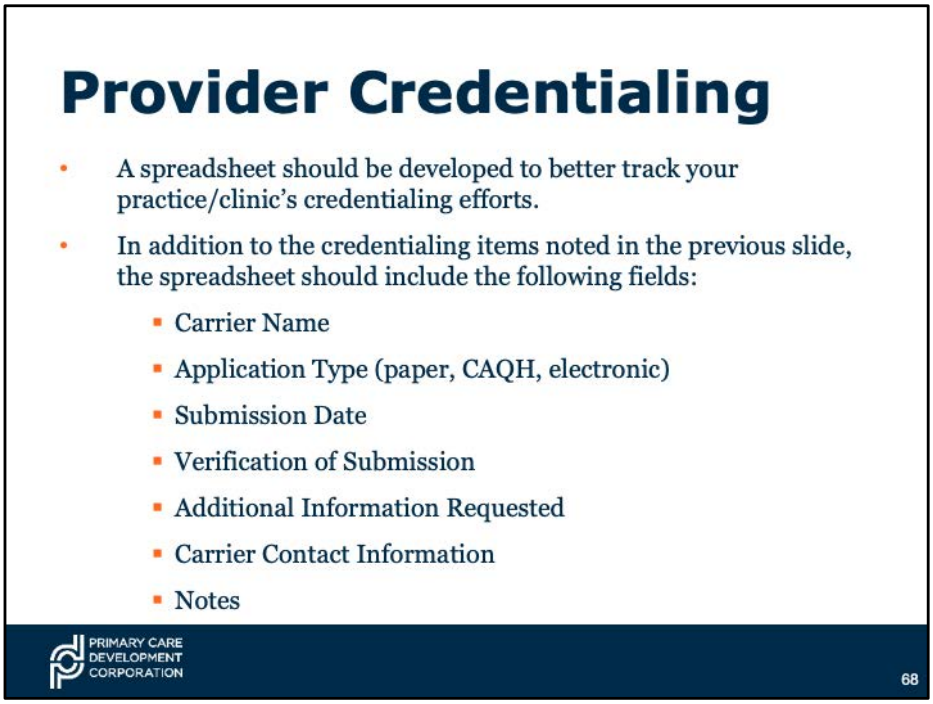
-Credentialing is a tedious verification process of a provider's education, licensure, certification and experience
-Maintaining up-to-date provider files is imperative for both H/R and Credentialing purposes



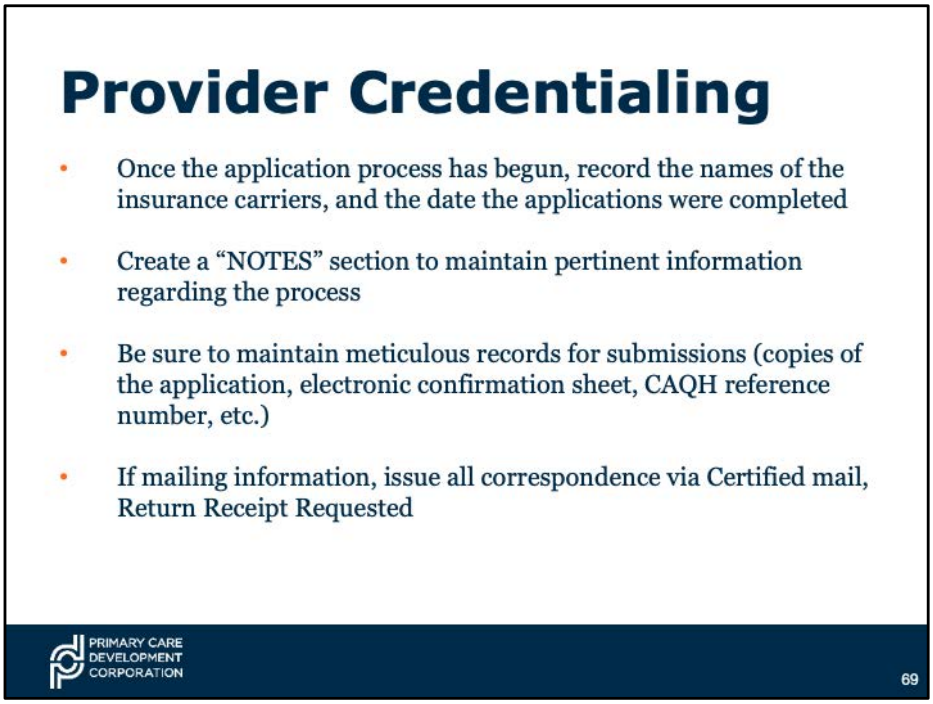
-Services must be billed in the name and NPI # of rendering provider. The only exception exceptions would be Medicare's incident-to guidelines and locum tenens/ reciprocal billing arrangements



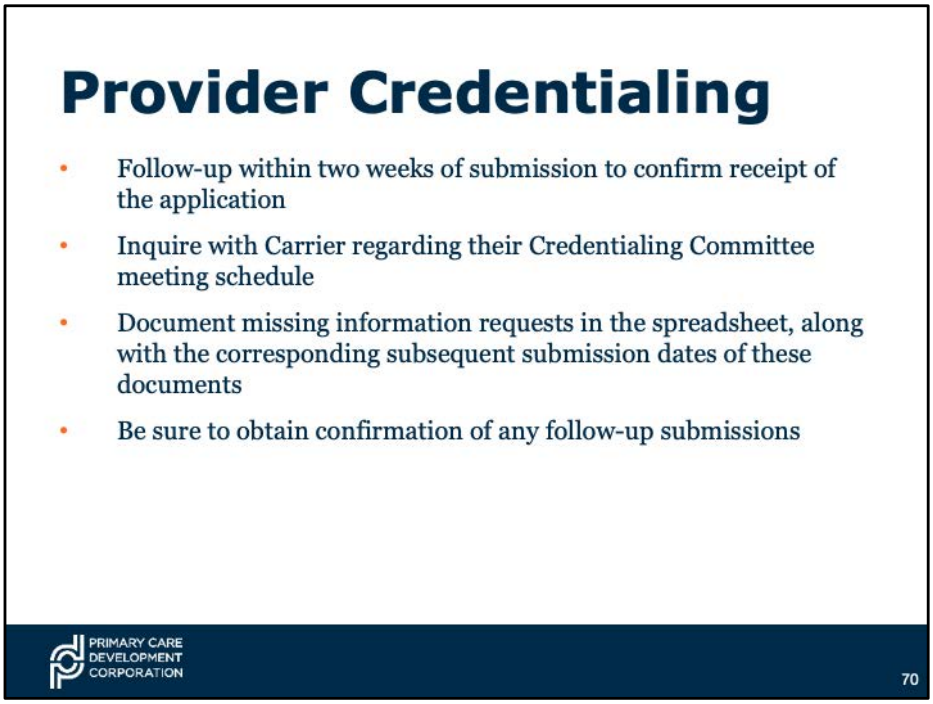
- Credentialing process:
- Check all collected documentation for expiration and/or recertification dates
- If a document has expired, a current document must be obtained prior to submission
- If document scanning is available, create a provider credentialing file and scan all documentation



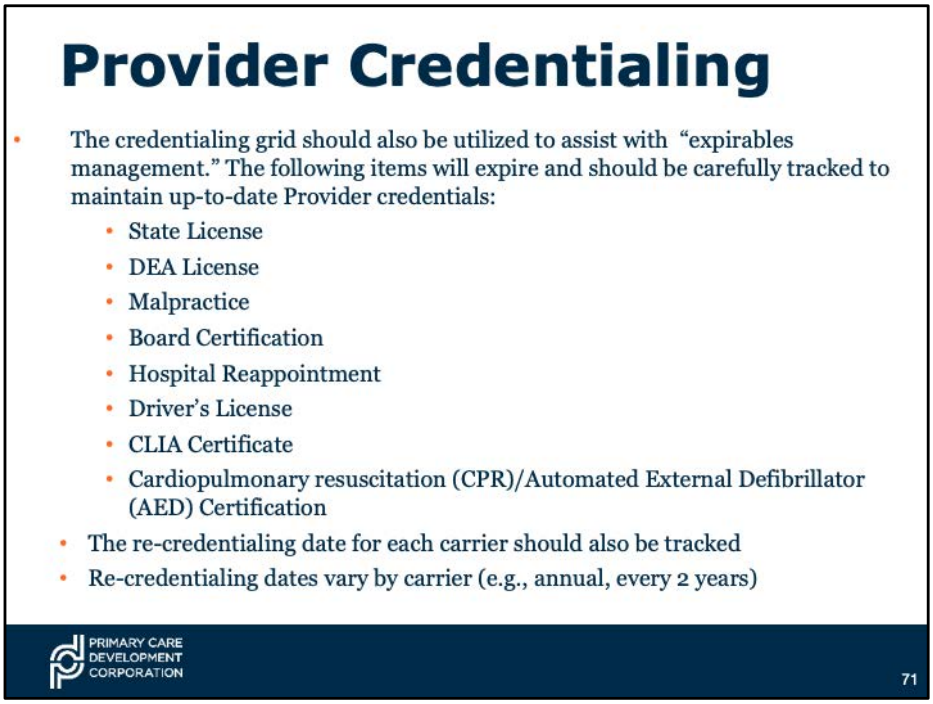
- Explain use of spreadsheet for tracking purposes
- Be careful when entering plan names, as many have similar sounding names (The Empire Plan and Empire BC/BS)
- Complete the application thoroughly



-Although a growing number of payers use the CAQH Universal Provider Datasource® and credentialing software can reduce the paperwork, most practices still manage this information "manually".
-When applications are completed with supporting documentation, scan/copy the application and all of the supporting documentation for internal purposes



-When speaking with a carrier representative, always be sure to obtain a name and reference number.
-Document all notes and information on the spreadsheet



-Track the expiration dates of any documents that can expire. Use the spreadsheet as your tracking tool.
-Expired documentation will halt the re-credentialing process.

Reimbursement for PrEP and PEP Services

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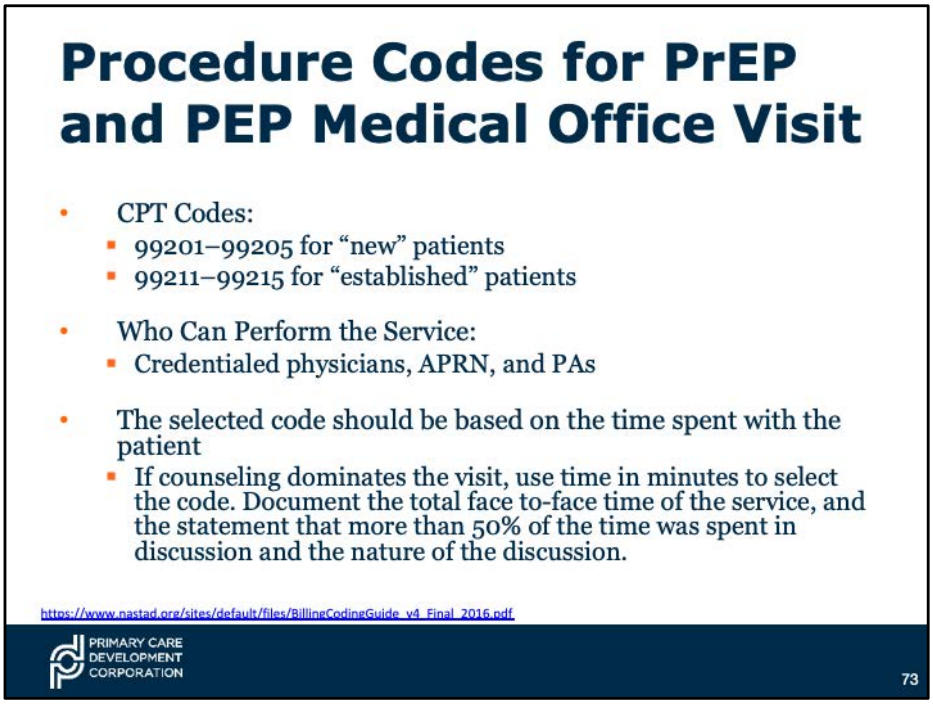

(e.g., I spent 15 minutes in face-to-face with Mr. XXX discussing the risks, benefits, limitations, possible complications, dosing, importance of adherence, and required conditions for continued prescribing of PrEP. He voiced an understanding and wishes to proceed).

Preventive Medicine Procedure Codes

- CPT 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

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

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Preventive Medicine Procedure Codes (cont.)

- 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."
- 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.

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

PrEP & PEP Billing Codes

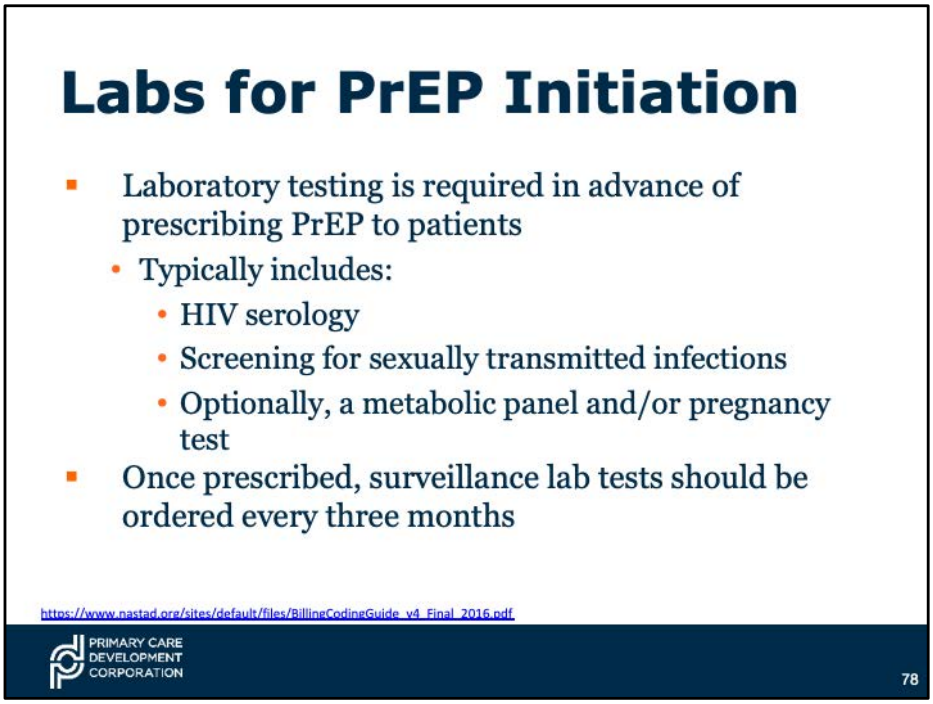
Category	ICD-10 Code	Description
Contact with and (suspected) exposure to communicable diseases	Z20.6	Contact with and (suspected) exposure to HIV
	Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
	Z20.89	Contact with and (suspected) exposure to other communicable diseases
	Z20.9	Contact with and (suspected) exposure to unspecified communicable diseases

http://publichealth.lacounty.gov/dhsp/Providers/PrEP-PEPBillingCodes.pdf

PrEP & PEP Billing Codes (cont.)

Category	ICD-10 Code	Description
High-risk sexual behavior	Z72.51	High risk heterosexual behavior
	Z72.52	High risk homosexual behavior
	Z72.53	High risk bisexual behavior
Other hazardous exposures	Z77.21	Contact with and (suspected) exposure to potentially hazardous body fluids
	Z77.9	Other contact with and (suspected) exposure hazardous to health

http://publichealth.lacounty.gov/dhsp/Providers/PrEP-PEPBillingCodes.pdf



A note about surveillance lab tests:
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.

Recommended Coding Guide

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
87537	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

https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf PG 19-20

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Questions?

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Follow up Office Hour!

- Looking for:
  - a deeper dive?
  - individual level support?
  - further discussion on billing & coding?
- Join us for a drop-in "office" hour with experts from today's webinar
- Monday, March 2 at 2:00 E/1:00 C/12:00 M/11:00 P
- Registration link (https://pcdc.zoom.us/webinar/register/WN_YBrAOGwYTH29Iw4yac3zAA) will be included in the post-webinar email

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PrimaryCareDevelopmentCorp @PrimaryCareDev

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Chaim Shmulewitz
Project Manager

Sustainable Strategies TargetHIV Link:
https://targethiv.org/ta-org/sustainable-strategies-rwhap-community-organizations

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