

Coding and Billing for HCV Testing Using



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 payor for any questions that arise when completing or submitting a claim for services.



Coding and Billing



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 Common Procedural Terminology (CPT) code 86803 should be used for common insurance carriers along with the 92 modifier code, while Medicare submissions should use 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 payors 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 www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html.

However, you should check with your individual payor to determine coverage and coding requirements for the test.



Q3.

What ICD-9-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 Table 3 & 5)

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 4)

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.

NOTE: *99241-99244 codes may or not be reimbursed by Medicare payors. Consult with specific payor 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 payor 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.

Table 1 – Laboratory Test Codes

CPT Codes	Description	Medicare Clinical Lab Fee Schedule National Limitation Amount
Correct Code		
86803 -QW or -92	Antibody; HCV, qualitative or quantitative single assay	\$19.62
Incorrect Codes		
86803	Antibody; HCV, qualitative or quantitative single assay	\$19.62
86804	Antibody; HCV, qualitative or quantitative confirmatory (e.g.immunoblot)	\$21.30

Table 2 – ICD-9-CM Diagnosis Codes

ICD-9-CM Codes	Description	Potential Use
070	Viral Hepatitis (include viral hepatitis (acute) (chronic symptoms of hepatitis infection	To describe services provided to viral hepatitis patients exhibiting
070.51	Acute hepatitis C without mention of hepatic coma	To describe services provided to an HCV-positive patient without hepatic coma; acute stage
070.54	Chronic hepatitis C without mention of hepatic coma	To describe services provided to an HCV-positive patient without hepatic coma; chronic stage
V69.8	Other problems related to lifestyle	To describe an asymptomatic patient
V73.89	Other problems related to lifestyle	To describe an asymptomatic requesting an HCV test
V02.60	Carrier or suspected carrier of unspecified viral hepatitis	To describe suspicion of hepatitis infection; unknown virus type
V02.62	Carrier or suspected carrier of viral hepatitis C	To describe suspicion of hepatitis C infection
V01.79	Contact with or exposure to communicable disease; Other viral diseases	To describe patients who are tested because of possible exposure

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	\$8.85 - \$199.37

*For more information: See www.cms.gov/medicare-coverage-database/indexes/contact-contractor-websites-index.aspx or the specific payor

Table 4 – Prevention/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	\$23.82 - \$109.21

Table 5 – Prolonged Service Codes

CPT Codes	Evaluation and Management Codes	Calculations Based on a Medicare Physician Fee Reimbursement Amount
Patient Visits		
99354 - 99355	Prolonged service beyond usual service	\$87.44 - \$97.31

Revised CMS-1500 Health Insurance Claim Form (08/05)

Changes in blue added by the ChiroCode Institute, www.chirocode.com • Source of changes: www.nucc.org/images/stories/PDF/final_1500_change_log.pdf

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID #)
GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NU BER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S a. OTHER INSURED'S b. OTHER INSURED'S c. EMPLOYER'S NAME		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
10. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information to the undersigned physician or supplier for the purpose of obtaining services or supplies. I also request payment of government benefits either to myself or to the party who below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information to the undersigned physician or supplier for the purpose of obtaining services or supplies. I also request payment of government benefits either to myself or to the party who below.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME ILLNESS OR INJURY GIVE FIRST DATE MM DD YY	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI		18. PRIOR AUTHORIZATION NUMBER	
19. RESERVED FOR LOCAL USE		20. RESERVED FOR LOCAL USE	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 of item 24E by Line) 1. VXX.XX		22. PRIOR AUTHORIZATION NUMBER	
23. DATE(S) OF SERVICE From MM DD YY to MM DD YY		24. PLACE OF SERVICE EMG	
25. PROCEDURES, SERVICES, OR SUPPLIES (explain unusual circumstances) CPT/HCPCS MODIFIER		26. CHARGES \$	
27. DAYS OF SERVICE G. DAYS OF SERVICE		28. EPISODES OF SERVICE H. EPISODES OF SERVICE	
29. QUALITY OF SERVICE I. QUALITY OF SERVICE		30. RENDERING PROVIDER ID # NPI	
31. CHARGE AL CHARGE		32. AMOUNT PAID 29. AMOUNT PAID	
33. BALANCE DUE 30. BALANCE DUE		34. PROVIDER INFO & PH # ()	
35. NPI NPI		36. APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)	

Block 21

Enter the appropriate ICD-9-CM "V" diagnosis code(s). It may be more than one code.

Block 24, Column E

For each CPT code, insert the number corresponding to the appropriate diagnosis code entered in Block 21.

Block 24, Column D

Enter the appropriate CPT codes along with appropriate modifiers:

- 86803-QW - describes the test
- 99XXX - describes E & M service

Note: Prevention/Risk Reduction and E&M codes are rarely submitted together. Consult your local provider for more information.

The above is provided as an example only. The health care provider is responsible for determining appropriate codes for an individual patient or for related and/or separate procedures.

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 payor policies concerning reimbursement in your area.

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

Doctor's Management, Inc.
phone: 800-635-4040

or

email: OQHCVReimburse@drsmgmt.com
(Use code OQHCV Reimburse for all inquiries)

Because private payor coverage policies and benefit plans differ greatly, the information offered in this guide may not be applicable for billing and reporting to private payors. The treating provider is responsible for determining the medical necessity for each specific patient case. Claims submitted to payors 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 ©2013 American Medical Association (AMA). All Rights Reserved. CPT is a trademark of the AMA.

OraSure Technologies

220 East First Street
Bethlehem, PA 18015 USA

phone: 800.ORASURE

web: www.OraSure.com

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