NASTAD

PrEP for HIV CMS National Coverage Determination (NCD):

Billing and Coding Supplement

February 2026

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Acknowledgments

This document was developed by NASTAD (National Alliance of State and Territorial AIDS Directors) in collaboration with, Caroline Peucker, a billing and coding expert and this document's primary author. NASTAD would also like to thank the following individuals that shared their time and expertise during the development of this guide, including but not limited to:

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Introduction

On September 30, 2024, the Centers for Medicare & Medicaid Services (CMS) released its final National Coverage Determination (NCD) regarding Medicare coverage for pre-exposure prophylaxis (PrEP). An NCD for Medicare is a national policy statement issued by CMS that determines whether Medicare will cover a specific medical item or service under Medicare Part B. Unlike LCDs (Local Coverage Determinations) issued by a Medicare Administrative Contractor (MAC) jurisdiction, which may vary by region, NCDs apply uniformly nationwide to all Medicare beneficiaries. Once issued, NCDs are mandatory, and MACs must adhere to them.

The NCD requires Medicare Part B to cover PrEP medication and ancillary services with no cost sharing for beneficiaries.[1][2] Medicare Part B typically covers provider visits, medical services, and provider-administered medications. However, Part B typically does not cover oral and other patient-administered medication, which are traditionally covered by Medicare Part D. To create a more seamless coverage route for PrEP and to ensure that Medicare beneficiaries could access all forms of PrEP - long-acting injectable and oral medication – without cost sharing, CMS shifted its coverage for PrEP oral medications from Part D to Part B starting in October 2024. This shift from Part D to Part B only applies to oral antiretroviral medications for PrEP; antiretroviral drugs for treating HIV continue to be covered under Part D.

The effective date of the NCD applies to services provided on or after **September 30, 2024**, which is the date the NCD was released. The **implementation date** is **April 7, 2025**, meaning that by this date, all MACs must be prepared to process claims in accordance with the NCD. **Services between the effective date and the implementation date bear special attention by the billing team to ensure they are reprocessed appropriately.**

Billing Team Alert!

Medicare MACs may not automatically process claims correctly when there is a gap between the NCD's effective date—**September 30, 2024**—and the date on which each MAC updates its system rules to comply with the new NCD.

The billing team should:

1. Gather all original Medicare PrEP claims between the effective date and the implementation date.
2. Review each claim to confirm whether it was processed correctly according to the NCD. Include review of payment amounts, cost-share amounts, and any denials in the review.
3. Resubmit any claims that were not processed in accordance with NCD 210.15

Medicare Advantage (MA) plans are not processed through the MAC. MA plans must provide the same coverage (for the same effective dates) as published in the NCD. An MA plan may develop additional billing rules. Refer to the Medicare Advantage Organization's medical policy page for billing and coding rules specific to that MA plan. Repeat the above steps for each MA plan's claims. Review the claims against the NCD criteria as well as the MA plan's payment policy.

[1] Fact Sheet: Medicare Part B Coverage of Pre-exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention: https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf

[2] CMS expanded Medicare Part B coverage using the "additional preventive services" benefit under section 1861(ddd)(1) of the Social Security Act. Coverage under this benefit category means that beneficiaries are not financially responsible for any cost-sharing obligations (i.e., deductibles or co-pays).

Purpose and Scope

This PrEP for HIV CMS National Coverage Determination (NCD) supplement is intended to be used in conjunction with the NASTAD Billing Coding Guide for HIV Prevention. The goal of this supplement is to provide up-to-date information about Medicare's coverage of PrEP for HIV Prevention based on the publication of NCD 210.15. At the time of the publication of NASTAD's 2023 Billing and Coding Guide, Medicare had not created HCPCS codes for PrEP counseling. Therefore, this supplement will provide updated guidance for billing PrEP counseling in conjunction with other Medicare-covered preventive services.

Codes and Coding for PrEP Services

CPT & HCPCS Coding

Several sets of codes were developed to translate healthcare services, diagnoses, procedures, equipment, and supplies into a standard alphanumeric language used to communicate between providers and payers. For a complete description and explanation of these code sets, see Section II, *Codes and Coding for Services (page 10),* in the NASTAD Billing Coding Guide for HIV Prevention.

CMS has primarily used HCPCS codes to identify covered preventive services. CMS has created HCPCS codes to define Medicare-covered PrEP services and supplies when no CPT codes existed that represented the preventive PrEP service. Those codes are referenced in this section and start with a "G**"**.

The codes described in the NASTAD Billing Coding Guide for HIV Prevention, **Section IX, Medicare Specific Codes,** remain valid, covered, and reportable. However, CMS has created additional codes to describe ***PrEP for HIV Prevention***. These new codes are described in this supplement. Additionally, it addresses a revision to correct coding practice when billing Medicare for PrEP counseling and Medicare-covered Annual Wellness Exams.

ICD-10 Coding

A detailed description of ICD-10 coding, including the specifics of PrEP ICD-10 coding, can be found throughout the NASTAD Billing Coding Guide for HIV Prevention. This information is particularly relevant in the Introduction, Section II: Codes and Coding for Services, and Section IV: ICD-10-CM Diagnosis Codes for HIV Prevention. Medicare has listed specific codes acceptable for creating compliant, payable claims for PrEP HIV Prevention services.

Z29.81 - Encounter for HIV pre-exposure prophylaxis **must always be the primary diagnosis code** for all PrEP claims for Medicare.

Additionally, other CMS-approved codes may be reported in the second and subsequent positions on the claim, if applicable. ICD-10 guidance indicates that these other diagnosis codes are used to describe conditions or statuses that exist at the time of the visit and may affect patient care and clinical decision-making. A complete list of codes CMS accepts for PrEP claims is included at the

end of this supplement. The original NASTAD Billing Coding Guide for HIV Prevention includes a more comprehensive list of ICD-10 codes that may apply to a PrEP encounter. However, only those codes listed in this NCD should be reported on Medicare PrEP claims.

What types of providers are impacted by this NCD?

- Physicians
- Nurse Practitioners
- Physician Assistants
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)[3] suppliers
- Medicare Part B pharmacy suppliers
- Rural Health Clinics and Federally Qualified Health Centers
- Any other provider who bills a Part B MAC for HIV preventive services

Who is eligible for this service?

All Medicare Part B beneficiaries for whom a health care practitioner determines are at increased risk for HIV.

What is covered by Medicare Part B?

For claims with dates of service on or after September 30, 2024, Medicare covers PrEP using antiretroviral drugs approved by the U.S. Food and Drug Administration (FDA) to prevent HIV in individuals at increased risk of HIV acquisition. Medicare also covers ancillary services for PrEP, including the supplying or dispensing drugs, administration of injectable PrEP, and specified lab and provider visits.[4]

1. FDA-approved PrEP antiretroviral drugs to prevent HIV
2. Administration of injectable PrEP
3. Supplying or dispensing the PrEP drug (whether taken orally or injected)
4. Up to eight (8) individual counseling visits every twelve (12) months. Counseling may include:
   - HIV risk assessment; initial or continued
   - HIV risk reduction
   - Medication adherence
5. Up to eight (8) HIV screening tests every 12 months
6. One (1) Hepatitis B screening (HBV)

[3] PrEP and associated services are not considered DMEPOS benefits for Medicare. However, DMEPOS claims processing procedure allows for an adjustment to beneficiary cost share as required for PrEP claims. Therefore, if a pharmacy is already a DMEPOS enrolled provider, it is not necessary for them to enroll as Part B providers too.

[4] National Coverage Determination (NCD) 210.15 Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention

The ancillary counseling and lab services for PrEP that Medicare must cover without cost-sharing are more limited than the ancillary services referenced in the USPSTF Grade A for PrEP and the CDC Clinical Guideline for PrEP. For example, Medicare is not required to cover regular STI screening, hepatitis C virus (HCV) screening, pregnancy tests, kidney function tests, or a lipid panel as part of the PrEP intervention. Some of these services may have stand-alone NCDs (for example HCV and STI screening) and could be covered without cost sharing based on that NCD.

1. FDA-approved PrEP antiretroviral drugs to prevent HIV

For Medicare patients to receive PrEP without cost-sharing, their PrEP medications must be dispensed by a pharmacy in the Medicare Part B network. To bill accurately for PrEP drugs, pharmacies must be enrolled as either 1) a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier (CMS855S), or 2) a Part B Pharmacy supplier (CMS-855B). CMS released Pharmacy-related fact sheets[5] and FAQs[6] leading up to the final NCD to help ease the transition to billing Medicare Part B. Pharmacies should verify their enrollment status with CMS using the Medicare Fee-For-Service Public Provider Enrollment dataset. Medicare provider enrollment information can be found here: CMS MLN Medicare Provider Enrollment educational Tool.

Part B Billing Warning!

For Medicare patients to receive PrEP with **no cost-sharing**, the PrEP medication must be dispensed by a **pharmacy that is able to bill Medicare Part B**. Patients and providers should verify that the pharmacy is enrolled and capable of billing PrEP under **Medicare Part B**, because Part B is the only part of Medicare that can process these claims with the **cost-sharing waived**.

As published in the Medicare Claims Processing Manual and NCD 210.15, CMS has approved the following HCPCS codes for PrEP. **Please note that all of the HCPCS codes listed in this NCD are drugs used for HIV prevention only. Do not use any HCPCS codes for the same drug that are used for HIV Treatment.** CMS has updated the descriptions of the codes below to indicate their use in HIV prevention.

Common Errors to Avoid

- **Confirm that the codes reported are specifically for HIV Prevention (not treatment).**
- **Report the Injection of PrEP with G0012 NOT 96372.**
- **Yeztugo was not included in NCD 210.15 at the time of publication. Confirm that the NCD has been amended to include it before billing Medicare for the drug.**

J0739	Injection, cabotegravir, 1mg, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV). ***Note for J0739:*** Report one (1) unit of J0739 for each 1 mg of cabotegravir administered.
J0750	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV)

[5] Fact Sheet: Medicare Part B Coverage of Pre-exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention; https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf

[6] PrEP for HIV National Coverage Determination (NCD) Technical Frequently Asked Questions for Pharmacies; https://www.cms.gov/files/document/faq-prep-hiv-06242024.pdf

J0751	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV)
J0799	FDA-approved prescription drug, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV), not otherwise classified ***Note for J0799:*** J0799 is a NOC (not otherwise classified) code. It does not represent a specific drug. It should be reported only when a more specific code for the particular FDA-approved HIV PrEP drug is not available. When reporting J0799, include; 1. the drug name 2. the manufacturer's name 3. the dosage administered, and 4. the NDC

Before October 1, 2025, the HCPCS code J0799 was used to report Lenacapavir for HIV Prevention. At the time of this publication, Lenacapavir (Yeztugo) has been approved by the FDA for HIV prevention. However, Lenacapavir is not included in the NCD, nor has the USPSTF Grade for PrEP been updated to include this medication. Therefore, at this time, Lenacapavir is not eligible for zero-dollar cost-sharing in Medicare. Please refer to NASTAD's Billing Coding Guide for HIV Prevention, specifically the Lenacapavir supplement, for coding and billing details.

ICD-10

- Report Z29.81 as the primary diagnosis code
- Report ICD-10 codes for increased risk factors in the second and subsequent positions.

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6	Z20.828	Z20.89	Z20.9	Z29.81	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52
Z72.53	Z72.89	Z79.899	Z86.59	Z87.898						

2. Administration of injectable PrEP

Refer to the NASTAD Billing Coding Guide for HIV Prevention Section VIII PrEP Drugs and Administration, which provides details regarding PrEP drugs and administration. The guide describes timing, associated laboratory testing recommendations, and coverage issues for non-Medicare payers.

Medicare has created and assigned a specific HCPCS code for the administration of PrEP long-acting injectable drugs. Report G0012 for each injection of a PrEP drug.

G0012	*Injection of pre-exposure prophylaxis (prep) drug for HIV prevention, under the skin or into the muscle*

****CPT code 96372 *Therapeutic, Prophylactic, and Diagnostic Injections and Infusions* is **NOT** used to report the administration of PrEP injectable drug for Medicare. ***

There is no administration code for oral PrEP, as these are typically self-administered. Self-administered drugs are medications that are used on an outpatient basis and that do not typically require clinical supervision or assistance to consume, apply, or inject.

ICD-10

- Report Z29.81 as the primary diagnosis code
- Report ICD-10 codes for increased risk factors in the second and subsequent positions.

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6	Z20.828	Z20.89	Z20.9	Z29.81	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52
Z72.53	Z72.89	Z79.899	Z86.59	Z87.898						

3. Supplying or dispensing the PrEP drug (whether taken orally or injected)

A pharmacy that supplies PrEP drugs may report and be paid a pharmacy supply fee. The pharmacy will bill either the Medicare Part B MAC or DMEPOS, depending on the provider's enrollment status.

Service Dates	Oral PrEP Supply Fee	Injectable PrEP Supply Fee
9/30/24 - 12/31/24	Q0516 (30d), Q0517 (60d), Q0518 (90d)	Q0519 (30d), Q0520 (60d)
On or after 1/1/25	Q0521 (replaces all previous codes)	Q0521 (replaces all previous codes)

Effective for dates of service from September 30, 2024, through December 31, 2024, a pharmacy will report one of the following supplying fees. The payable PrEP drug must be billed on the same claim as the supplying fee for the claim to be paid.[7]

Q0516	Pharmacy supplying fee for HIV pre-exposure prophylaxis, FDA-approved prescription oral drug, per 30 days;
Q0517	Pharmacy supplying fee for HIV pre-exposure prophylaxis, FDA-approved prescription oral drug, per 60 days;

[7] Medicare Claims Processing Manual, Chapter 18, Section 250.3 F. https://www.cms.gov/files/document/r13209cp.pdf-0#page=31

Q0518	Pharmacy supplying fee for HIV pre-exposure prophylaxis, FDA-approved prescription oral drug, per 90 days;
Q0519	Pharmacy supplying fee for HIV pre-exposure prophylaxis, FDA-approved prescription injectable drug, per 30 days
Q0520	Pharmacy supplying fee for HIV pre-exposure prophylaxis, FDA-approved prescription injectable drug, per 60 days

Effective for claims with dates of services on or after 1/1/2025, the HCPCS codes listed above, Q0516-Q0520, are replaced by:

Q0521	Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA-approved prescription Medicare will deny claims if the supplying fee HCPCS codes are not billed on the same claim as a payable covered PrEP drug. [8]

ICD-10

- Report Z29.81 as the primary diagnosis code
- Report ICD-10 codes for increased risk factors in the second and subsequent positions.

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6,	Z20.828	Z20.89	Z20.9	Z29.81	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52
Z72.53	Z72.89	Z79.899	Z86.59	Z87.898						

4. Up to eight (8) individual counseling visits every twelve (12) months

Medicare will pay for up to eight counseling services related to PrEP HIV Prevention every 12 months. A physician or other healthcare practitioner must provide the counseling service. Individuals must be competent and alert at the time that counseling is provided. Any combination of the following counseling services contributes to the maximum allowed.

Counseling may include:

a. HIV risk assessment; initial or continued

b. HIV risk reduction

c. Medication adherence

[8] Medicare Claims Processing Manual, Chapter 18, Section 250.3 F. https://www.cms.gov/files/document/r13209cp.pdf-0#page=31

Report **G0011** for HIV prevention counseling if;

- Individual counseling is a one-on-one session between a beneficiary and a physician or qualified health professional
- The counseling lasts between 15 and 30 minutes. ***Note: If PrEP counseling is provided for less than 15 minutes, it does not satisfy the minimum time threshold for billing this code. Additionally, billing for other forms of counseling in place of PrEP services may not be reimbursable and may not be eligible for zero patient cost-share.***
- The counseling includes HIV risk assessment, HIV risk reduction, or HIV prevention medication adherence.
- Documentation must include the provider name, the time spent, and the topics about which the patient was counseled.

Report **G0013** for HIV prevention counseling if;

- Individual counseling is a one-on-one session between a beneficiary and clinical staff that is not a physician or qualified health professional
- The counseling includes HIV risk assessment, HIV risk reduction, or HIV prevention medication adherence.
- Documentation should include the name of the staff member providing the counseling, the time spent, and the topics about which the patient was counseled.

G0011 and G0013 represent the same counseling services but are rendered by different provider types. Therefore, these codes would not be billed together for the same beneficiary on the same day.

ICD-10

- Report Z29.81 as the primary diagnosis code
- Report ICD-10 codes for increased risk factors in the second and subsequent positions.

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6	Z20.828	Z20.89	Z20.9	Z29.81	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52
Z72.53	Z72.89	Z79.899	Z86.59	Z87.898						

5. Up to eight (8) HIV screening tests every 12 months

Medicare will pay for up to eight (8) HIV screening tests every twelve (12) months for beneficiaries being assessed for or using PrEP for the prevention of HIV. Refer to NASTAD Billing Coding Guide for HIV Prevention Section VII Labs for PrEP Initiation and Supplemental Testing for additional lab codes, modifiers, and descriptions.

The following codes are covered by Medicare when performing HIV screening tests. Choose and report the code that represents the testing method used.

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 antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening, G0475 - Hiv antigen/antibody, combination assay, screening,
G0475	HIV antigen/antibody, combination assay, screening
80081	OB Panel (complete blood count (CBC) with differential, Hepatitis B surface antigen test, HIV antigen/antibody test, qualitative syphilis test, ABO and Rh blood typing, and an RBC antibody screen

ICD-10

- Report Z29.81 as the primary diagnosis code
- Report Z11.4 in the second position
- Report ICD-10 codes for increased risk factors in the third and subsequent positions.

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6	Z20.828	Z20.89	Z20.9	Z29.81	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52
Z72.53	Z72.89	Z79.899	Z86.59	Z87.898						

6. One (1) Hepatitis B screening (HBV)

Medicare will pay for one HBV screening code for beneficiaries being assessed for or using PrEP to prevent HIV. This covered HBV screen is a one-per-lifetime allowance for PrEP. However, Medicare beneficiaries may be entitled to additional HBV screening without cost sharing if they meet the criteria in the separate HBV Screening NCD under NCD 210.6.

The following codes are covered by Medicare when performing HBV screening tests. Choose and report the code that represents the testing method used.

G0499	HBV screening in non-pregnant, high-risk individuals includes hepatitis B surface antigen (hbsag), antibodies to hbsag (anti-HBs), and antibodies to hepatitis B core antigen (anti-Hbc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive hbsag result
87340	Hepatitis B surface antigen (HBsAg)

87341	Hepatitis B surface antigen (HBsAg) neutralization
86704	Hepatitis B core antibody (HBcAb); total
86706	Hepatitis B surface antibody (HBsAb)

Medicare Annual Wellness Exam and PrEP counseling

The NASTAD Billing Coding Guide for HIV Prevention addresses the Medicare Initial Preventive Physical Exam (IPPE) (G0402) and Medicare Annual Wellness Visit (AWV) (G0438 and G0439). The components of these two covered services remain unchanged. See pages 45-46 of the 2023 guide. However, following the publication of NCD 210.15 and the creation of HCPCS code G0011, some of the original guidance requires amendment.

If PrEP counseling was rendered and documented during the office encounter, it may be reported in addition to G0402, G0438, and G0439. At the time of this publication, there are no NCCI edits that prohibit this code pair. Additionally, PrEP counseling for HIV risk assessment, HIV risk reduction, and medication adherence are not components of IPPE nor AWV services.

- Document the time and topics of the PrEP counseling separately from the documentation of time for the IPPE or AWV service.
- Report G0011 for the individual by a physician or qualified health professional. Note that G0013 would not be applicable in this situation, as a clinical staff member would not be providing the IPPE or the AWV service.
- Append Modifier 25 to G0402, G0438, or G0439 HCPCS codes.
- Link ICD-10 code for general adult medical exam Z00.00 or Z00.01 to the IPPE or AWV, and link Z29.81 to G0011 PrEP counseling code.

Medicare Denials

The NASTAD Billing Coding Guide for HIV Prevention describes how claim denials appear on the Remittance Advice (also known as EOBs). Payers, including Medicare, use a standard set of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to describe the reasons for denials. Refer to the NASTAD Billing Coding Guide for HIV Prevention Glossary for definitions of the Remittance Advice data element.

In the CMS MLN Matters publication on National Coverage Determination 210.15: Pre-Exposure Prophylaxis (PrEP) for HIV Prevention, CMS outlines potential reasons for denial and the standard RA language Medicare will use to explain the rationale.

Understanding Medicare's PrEP denial language

"We deny claims that exceed the allowed frequency and use these messages:

- CARC 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N640 – Exceeds number/frequency approved/allowed within the time period.
- MSN message 41.14 – This service/item was billed incorrectly.
- Claim Adjustment Group Code – CO (Contractual Obligation) or PR (Patient Responsibility), dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

We deny claims for an HBV screening test with primary diagnosis code Z29.81 if you haven't also submitted a PrEP for HIV service, and we use these messages:

- CARC 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 – This decision was based on a National Coverage Determination (NCD).
- MSN message 15.20 – The following policies were used when we made this decision: NCD 210.15.
- Claim Adjustment Group Code – CO (Contractual Obligation) or PR (Patient Responsibility), dependent upon liability. (Use PR when Occurrence Code 32 (Institutional claim) or the GA modifier (Professional claim) is appended to the line item).

We pay for PrEP for HIV claims using antiretroviral drugs (G0012, J0739, J0799, J0750, or J0751) to prevent HIV infection in patients at increased risk of acquiring HIV using 1 of the diagnosis codes listed in the Medicare Claims Processing Manual, Chapter 18, section 250.2. We deny claims that don't contain 1 of the HCPCS codes for PrEP for HIV, along with one of the diagnosis codes, and use these messages:

- CARC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 – This decision was based on a National Coverage Determination (NCD).
- MSN message 15.20 – The following policies were used when we made this decision: NCD 210.15.
- Group Code – CO (Contractual Obligation)."[9]

[9] National Coverage Determination 210.15: Pre-Exposure Prophylaxis (PrEP) for HIV Prevention https://www.cms.gov/files/document/mm13843-national-coverage-determination-21015-pre-exposure-prophylaxis-prep-hiv-prevention.pdf

ICD-10 Coding for NCD 210.15

The following codes are listed in NCD 210.15 Pre-Exposure Prophylaxis (PrEP) for HIV Prevention.

- Z29.81: Encounter for HIV pre-exposure prophylaxis
- Z11.4: Encounter for screening for human immunodeficiency virus [HIV]
- Increased risk factors reported:

A51.31	A51.32	A51.39	A51.41	A51.42	A51.43	A51.44	A51.45	A51.46	A51.49	A52.01
A52.02	A52.03	A52.04	A52.05	A52.06	A52.09	A52.11	A52.12	A52.13	A52.14	A52.15
A52.16	A52.17	A52.19	A52.2	A52.71	A52.72	A52.73	A52.74	A52.75	A52.76	A52.77
A52.78	A52.79	A53.0	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22
A54.23	A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.41	A54.42	A54.43	A54.49
A54.5	A54.6	A54.81	A54.82	A54.83	A54.84	A54.85	A54.86	A54.89	A56.01	A56.02
A56.09	A63.8	A64	F11.10	F11.20	F11.21	F11.90	Z11.3	Z11.59	Z13.29	Z20.2
Z20.5	Z20.6	Z20.828	Z20.89	Z20.9	Z32.00	Z32.01	Z32.02	Z72.51	Z72.52	Z72.53
Z72.89	Z79.899	Z86.59	87.898							

Billing & Coding FAQs

1. **Can I bill for a visit (E&M) code when it occurs during the same encounter as HIV Prevention Counseling?**

   Yes, but only if specific criteria are met. If those criteria are not met, they may be billed, but are not guaranteed to be paid. Billing for multiple service codes on the same day by the same provider to the same patient is discussed extensively in the NASTAD Billing Coding Guide for HIV Prevention. Please see Sections V, "PrEP Visits," and Section IX. Medicare Specific Codes. Modifier 25 can be reported to indicate that ***"a significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service"*** occurred and is documented. The E&M service must be linked to a problem-related ICD-10 code, not Z29.81. As stated previously, Modifier 25 is a powerful tool that should be used prudently. Medicare may still deny the claim and request additional documentation to support its validity.

   Additionally, while Medicare may pay for the additional service, it does not assume the covered preventive status of the PrEP service codes. That is, the additional codes may be subject to deductible, copay, and coinsurance rules. Refer to the NASTAD Billing Coding Guide for HIV Prevention PrEP E&M Decision Tree

2. **For services with limits on the number of visits or labs allowed per year, how do I determine if the patient has reached the limit?**

   CMS has created a tool that not only checks Medicare eligibility in general, but also checks eligibility for specific types of benefits, including Preventive Services Eligibility Data. The data set that Medicare will return for your Medicare fee-for-service (FFS) inquiry includes paid claims for preventive services, including the NPI of the past rendering provider. For a Medicare Advantage (MA) enrollee, the eligibility response shows the patient's MA plan, the plan's effective and termination dates, and the plan's contact information. Direct other eligibility queries to the identified plan in the response. CMS does not

have plan coverage and paid claims information to determine eligibility for items or services. If you work with a third-party entity, such as a billing agency, clearinghouse, or software vendor, they may already have an interface built to use this inquiry. Ask for their EDI (Electronic Data Interchange) team. The standard (ANSI X12) format for insurance eligibility, including Medicare, is the EDI 270 transaction set. [10]
https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf

3. **Where can I find information on other Medicare-covered preventive services?**

   Medicare has created an Educational Tool for covered preventive services, available at CMS MLN Medicare Preventive Services Educational Tool. It contains links to all preventive services, NCDs, FAQs, and resources.

4. **Must the ICD-10 code Z29.81 be in the primary position for every PrEP for HIV Prevention Medicare claim?**

   Yes, Z29.81 is the key piece of data that identifies a claim as an ***Encounter for HIV pre-exposure prophylaxis***. CMS has instructed the MACs in the Medicare Claims Processing Manual to look for this ICD-10 code in the primary position specifically, and to pay or deny claims based on the CPT code and frequency as defined in this NCD.

5. **What is a Qualified Health Professional (QHP)?**

   HCPCS code G0011 indicates that counseling must be provided by a physician or a qualified healthcare professional (QHP). For Medicare, a Qualified Healthcare Professional (QHP) is an individual who is qualified by education, training, licensure, and experience to perform professional services within their scope of practice independently and bill for those services. This distinguishes them from "clinical staff" who work under QHP supervision. Examples of QHPs may include physicians, nurse practitioners, physician assistants, and certified nurse specialists. For other payers, this definition may vary due to state regulations, payer-specific definitions, and enrollment rules.

6. **Will FQHCs and RHCs be paid an encounter rate (PPS or AIR) if PrEP counseling is the reason for an encounter?**

   Yes[11]. According to CMS NCD 210.15, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) practitioners can bill for individual counseling when they perform these services in RHCs and FQHCs.
   - RHCs bill G0011 with a CG modifier, and payment is at the all-inclusive rate (AIR).
   - FQHCs
     - Bill G0011, along with the appropriate FQHC-specific payment code (G0466 or G0467). Payment is at the lesser of charges or the FQHC PPS rate.
     - PrEP for HIV Counseling HCPCS Code G0011 is considered a visit for FQHCs when furnished by an FQHC Practitioner.
     - G0013 is not considered a qualifying visit code because it is performed by clinical staff, not during a face-to-face visit with an FQHC practitioner. The service is bundled into the FQHC PPS rate.
     - If the PrEP Counseling service occurs on the same day as another qualifying medical visit, it is not separately billable.

[10] X12.org X12, chartered by the American National Standards Institute for more than 40 years, develops and maintains EDI standards https://x12.org/products/transaction-sets

[11] Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) andFederally Qualified Health Center (FQHC) Services, Section 220.1 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf

7. **Is an FQHC allowed to bill for PrEP medications as well as the visit?**

   Yes, CMS's MLN Federally Qualified Health Center booklet[12] addresses this issue specifically. Effective September 30, 2024, Medicare Part B covers pre-exposure prophylaxis (PrEP) for HIV drugs and other services to decrease an individual's risk of acquiring HIV without cost-sharing.

   For claims with dates of service from September 30 to December 31, 2024, RHCs and FQHCs should include costs for PrEP for HIV drugs, as well as any supply and administration fees, on their cost reports.

   Starting January 1, 2025, Medicare will pay FQHCs 100% of the Medicare payment amount for PrEP drugs, as well as any supply and administration fees, on a claim-by-claim basis.

   To bill for PrEP on or after January 1, 2025, RHCs and FQHCs can use an institutional claim form to bill Medicare, just as they bill for other medical services. RHC and FQHC pharmacies should coordinate with their medical billing areas for this purpose.

   Since these services can be billed and paid separately from the FQHC PPS and RHC AIR, a claim for PrEP for HIV won't cause any same-day billing denials.

   RHCs and FQHCs can bill PrEP alone or in addition to other services.

8. **Where can I find more information on enrolling as a Part B provider or DMEPOS supplier?**

   - Medicare Provider Enrollment: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html#Enrollment
   - CMS PrEP FAQ - How do I Enroll? https://www.cms.gov/medicare/coverage/prep#:~:text=CMS%20covers%20HIV%20prevention%20services,competent%20and%20alert%20during%20counseling
   - Fact Sheet: Medicare Part B Coverage of Pre-exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention: https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf

[12] Federally Qualified Health Center; MLN updated April 2025 page 11 https://www.cms.gov/files/document/mln006397-federally-qualified-health-center.pdf

PrEP for HIV National Coverage Determination (NCD) Technical Frequently Asked Questions for Pharmacies

The below FAQ was developed by CMS and has been referenced throughout the document. It can also be accessed in the resource list.

PrEP for HIV National Coverage Determination (NCD) Technical Frequently Asked Questions for Pharmacies

Background

Why is CMS posting these FAQs?

CMS received public feedback asking that more technical information for submitting Medicare Part B claims for PrEP for HIV be released. Also see the fact sheet at https://www.cms.gov/ files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf.

What does the final NCD cover?

CMS, under Medicare Part B, covers Pre-exposure Prophylaxis (PrEP) and other related services to prevent HIV without cost-sharing (i.e., deductibles or co-pays under Part B). Visit PrEP for HIV & Related Preventive Services https://www.cms.gov/medicare/coverage/prep. The final NCD was published on September 30, 2024, and is available at https://www.cms.gov/medicare-coverage-database/view/ncacal-tracking-sheet.aspx?NCAId=310.

Enrollment

Are pharmacies currently enrolled in Medicare as durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) suppliers required to also enroll as Part B Pharmacy suppliers?

No. If a pharmacy is already enrolled as a DMEPOS supplier, the pharmacy can submit claims for PrEP for HIV drugs and for dispensing/supplying those drugs to their DME Medicare Administrative Contractor (MAC). The DME MAC is where DMEPOS supplier pharmacies currently send claims and they process claims for PrEP for HIV drugs and the dispensing/supplying of those drugs.

If a pharmacy is not already enrolled as a Medicare provider, which pathway to enrollment should they choose (either a DMEPOS supplier or a Part B Pharmacy supplier)?

We recommend that pharmacies consider enrolling as a Part B pharmacy supplier because of the lower burden of enrollment. There are additional enrollment requirements for DMEPOS suppliers as they are required to meet supplier standards, accreditation and have a surety bond. Revalidation of Part B Pharmacies is less frequent than revalidation for DMEPOS suppliers. Claims submitted by Part B Pharmacies are submitted to their A/B MAC. For more information on pharmacy enrollment, listen to this webinar or view the transcript and visit https://www.cms.gov/medicare/coverage/prep and see the "How Do I Enroll" section.

If I am a pharmacy enrolled only to "roster bill" Medicare for vaccinations, could I also bill for PrEP for HIV drugs and dispensing/supplying using this mechanism?

No. Roster billing is not an appropriate mechanism to bill for these additional preventive services. Pharmacies need to be enrolled as either a Part B Pharmacy supplier or a DMEPOS supplier.

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Billing Medicare Part B

*Note: Throughout this document, we refer to billing "Medicare Part B," which can apply to billing the DME MAC or the Part A/B MAC depending on the pharmacy's enrollment type.

I am a DMEPOS pharmacy accustomed to the Medicare DMEPOS billing and documentation requirements for various DME. Do the same payment requirements apply to billing Medicare Part B (either billing the DME MAC as an enrolled DMEPOS supplier or billing the A/B MAC as a Part B pharmacy supplier) for HIV PrEP drugs?

The following DMEPOS) payment requirements are not applicable when billing PrEP for HIV drugs under the NCD:

- The DMEPOS order, face-to-face, and refill requirements stated in 42 CFR 410.38;
- Any 30-day limitations for initial supplies and refills.

We note faxed and electronic prescriptions can be used (ink or wet signatures are not required).

Do pharmacies need to submit a diagnosis code with a claim to Medicare Part B?

Pharmacies need to append at least one valid diagnosis code (ICD-10 CM) to claims submitted to Medicare Part B. There are multiple diagnosis codes that may be appropriate under this NCD. These may include:

- Z29.81: Encounter for HIV pre-exposure prophylaxis
- Z11.4: Encounter for screening for human immunodeficiency virus [HIV]
- Increased risk factors reported: Z11.4, Z29.81, Z20.6, Z20.2, Z11.3, Z11.59, Z20.5, Z79.899, Z86.59, Z87.898, Z72.89, F11.10, F11.20, F11.21, F11.90, Z72.51, Z72.52, Z72.53, Z72.89, Z32.00, Z32.01, Z32.02, Z20.828, Z20.89, Z20.9

What are the expectations of the pharmacy when it comes to PrEP drugs?

The dispensing pharmacy is expected to have and maintain the order from the ordering physician or non-physician practitioner and proof of delivery (i.e., a signed receipt or some other indication the item was dispensed to the beneficiary). The diagnosis code should be obtained from the ordering practitioner. At this time CMS has determined it is appropriate to deprioritize the review of these claims so that all involved parties can transition to the new environment.

What codes are available to pharmacies to bill PrEP for HIV drugs to Medicare Part B?

New codes have been established and are available for use:

- J0799 - FDA approved prescription drug, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV), not otherwise classified, Short Descriptor: HIV prep, FDA approved, noc
- J0750 - Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg, oral, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV), Short Descriptor: HIV prep, ftc/tdf 200/300 mg
- J0751 - Emtricitabine 200 mg and tenofovir alafenamide 25 mg, oral, FDA approved prescription, only for use as pre-exposure prophylaxis (not for use as treatment of HIV), Short Descriptor: HIV prep, ftc/taf 200/25 mg
- J0739 - Injection, cabotegravir, 1 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) Short Descriptor: Injection, cabotegravir, 1 mg
- Q0516 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days

- Q0517 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days
- Q0518 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days
- Q0519 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days
- Q0520 - Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days

What date of service should be used on Medicare claims for dispensing/supplying HIV PrEP drugs?

The date of service on the claim should be the date the drug is picked up from the pharmacy or, if a mail order pharmacy, the date the drug is mailed. The claim should not include span dates.

Can pharmacies bill for oral and injectable PrEP for HIV drugs?

Yes. Medicare Part B covers these drugs as additional preventive services and Medicare covers the service of supplying the drug. There may also be instances when the injectable PrEP for HIV drug is supplied by the pharmacy to the provider for subsequent administration by a physician or health care practitioner qualified to administer the drug.

Do claims submitted to Medicare Part B have to include both the code for the PrEP for HIV drug and the code for supplying the drug?

To bill Medicare Part B for the supplying fee, it must be on the same claim as the Medicare claim for the covered drug.

Can pharmacies supply and bill Medicare Part B for more than a 30-day supply of oral PrEP for HIV drugs?

Yes. There are three codes available to bill the supplying fee for oral PrEP for HIV with 30, 60 and 90-day options. Only one of these supplying codes may be on the claim.

Can pharmacies bill a supply fee if they fill a prescription for injectable PrEP for HIV and provide the drug to the beneficiary?

Yes, there are two supply codes for the injectable PrEP for HIV drug. Only one of these supplying codes may be on the claim.

Can the pharmacy also bill a supply fee if they provide the injectable drug directly to the practitioner?

The supply fee must be billed on the same claim as the PrEP for HIV drug. If the practitioner bills Medicare Part B for the PrEP for HIV drug, the pharmacy is not able to bill for the drug and therefore, not able to bill the supply fee. We understand in such arrangements that the pharmacy may invoice the practitioner.

Must a pharmacy include the National Provider Identifier (NPI) of the ordering physician or non-physician practitioner on a Medicare claim?

Medicare Part B claims submitted to a DME MAC must include the name and NPI of the enrolled ordering/referring physician or non-physician practitioner in order for the claim to process. This information should also appear on claims submitted to A/B MACs. The name and NPI must appear in the Order and Referring dataset. This dataset provides information on all physician and non-physician

practitioners, by their NPI, who are of a type/specialty that is legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare. Pharmacists do not appear in the dataset and cannot order PrEP drugs for payment under Medicare Part B. For more information, please visit https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring and for information about who can order and certify please see https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/ordering-certifying.

Can pharmacists furnish PrEP related services?

Currently, under Medicare Part B, pharmacists are not eligible for direct payment for services furnished to Medicare patients. That is, if a pharmacist, under state scope of practice laws, furnishes counseling, injects a PrEP drug or orders PrEP, those services cannot be paid directly to the pharmacist and the drugs cannot be paid by Medicare Part B. Pharmacists may provide, when all conditions are met, services as auxiliary personnel "incident to" a physician's or other practitioner's service in certain settings. The incident to regulations require supervision by a physician or other practitioner, and such services would be billed by the supervising physician or practitioner. For further details regarding "incident to" services, we recommend that interested parties consult 42 CFR §§ 410.26 and 410.27 and https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-providers/incident-services-supplies.

How are the PrEP for HIV drugs and supply fees priced?

In accordance with this National Coverage Determination (NCD), Medicare Administrative Contractors (MACs) will publicly post the payment allowances for the HCPCS codes for the PrEP for HIV drugs and supply fees. Please check the website of your MAC and contact them directly with questions. https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs.

We note that the CY 2025 Medicare Physician Fee Schedule (PFS) (89 FR 61930 through 61934) and CY 2025 Outpatient Prospective Payment System (OPPS) (89 FR 59399 through 59402) proposed rules included proposals that specified pricing for drugs covered as additional preventive services (DCAPS), such as PrEP for HIV drugs, proposed to be effective beginning on January 1, 2025. CMS will issue the final CY 2025 PFS and final CY 2025 OPPS rules in late fall 2024, which will further address these payment policy proposals.

Is CMS requiring reporting of modifiers on the HIV PrEP drugs and services claims?

No. CMS is not requiring any modifiers on claims related to this NCD. Claims will be processed by the DME MAC or A/B MAC without any modifier; however, the presence of a modifier should not, in itself, result in a claims rejection.

How should a pharmacy bill if the beneficiary has a Medicare Advantage plan?

Medicare Advantage plans must follow this National Coverage Determination (NCD), including providing PrEP drugs for HIV with no cost sharing at in-network providers beginning on September 30, 2024, the date this NCD was issued. Payment for PrEP drugs and services under this NCD for a Medicare enrollee should be billed to the enrollee's Medicare Advantage plan, not Original Medicare. Please see the August 1, 2024, HPMS memo for additional information about billing and contact the Medicare Advantage plan for further information.

If a pharmacy is not enrolled in Part B and the person with Medicare has to go elsewhere, what can I do to help them find an alternative pharmacy?

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Some smaller pharmacies aren't set up to process drugs covered by Part B (Medical Insurance). If you go to a pharmacy and they can't bill Medicare for PrEP, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. We'll help you find another pharmacy where you can get your PrEP. A mail order pharmacy may be available.

Resources

PrEP for HIV National Coverage Determination (NCD) Technical Frequently Asked Questions for Pharmacies https://www.cms.gov/files/document/faq-prep-hiv-06242024.pdf

Fact Sheet: Medicare Part B Coverage of Pre-exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf

MLN Matters *National Coverage Determination 210.15: Pre-Exposure Prophylaxis (PrEP) for HIV Prevention* https://www.cms.gov/files/document/mm13843-national-coverage-determination-21015-pre-exposure-prophylaxis-prep-hiv-prevention.pdf

CMS Manual System Pub 100-03 Medicare National Coverage Determinations Centers for Medicare & Medicaid Services (CMS) Transmittal: 12987 Change Request 13843 https://www.cms.gov/files/document/r12987NCD.pdf

CMS Manual System Pub 100-04 Medicare Claims Processing Transmittal 13209 Change Request 13843 https://www.cms.gov/files/document/r13209cp.pdf-0#page=31

CMS MLN Medicare Preventive Services Educational Tool https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html

CMS MLN Fact Sheet - Checking Medicare Eligibility https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf

Glossary

Entry	Definition & Links
AMA	American Medical Association
Appeals	Oral or written communication from a provider (or representative of the provider) to a payer to attempt to overturn a previously denied or inappropriately processed claim.
Buy & Bill	A process by which a physician or practice can purchase medications, administer them in the office, and bill directly to the payer.
Cabotegravir	CAB is a single antiretroviral drug given as an intramuscular injection every two months to prevent HIV. Currently, this is only available as a brand-name drug, Apretude®.
CARC	Claim Adjustment Reason Codes: A set of standardized codes applied to a claim by a payer to provide the reason for the billed amount being different from the allowed amount. X12 CARC
CDC	Centers for Disease Control and Prevention CDC is the nation's leading science-based, data-driven, service organization that protects the public's health. CDC Homepage
CMS	Center for Medicare and Medicaid Services: is the U.S. federal agency that works with state governments to manage the Medicare program, and administer Medicaid and the Children's Health Insurance program. CMS Homepage
Cost Share	This term refers to the share of medical care costs that your insurance covers, which the patient pays out of pocket. This term can include deductibles, co-insurance, or co-payments. It does not refer to balances due for services not covered by the plan.
CPT	Current Procedural Terminology (Level I codes) are codes created by the AMA that offer a uniform language for coding medical services. The US DHHS approves CPT codes as the US national coding set. This code set describes the services provided to a patient. AMA CPT information
Denial	An insurance denial occurs when an insurer refuses to pay a claim, typically due to a lapsed policy, missing or inaccurate information, pre-existing conditions, or the service not being covered under the plan's terms. It can also occur if the patient or provider fails to follow the plan's rules, such as failing to obtain prior authorization or using an out-of-network provider without a valid reason.

Denial Codes	Codes assigned by a payer to a claim to indicate the reason for non-payment.
DMEPOS	Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies. Medicare Part B covers medically necessary equipment, devices, and supplies that fall under several benefit categories defined in section 1861 of the Social Security Act, commonly referred to as DMEPOS.
E & M	Evaluation & Management: E&M or E/M codes are CPT codes that represent services provided by a physician or other qualified and licensed healthcare professional. These services are medical and cognitive in nature, which allow a provider to evaluate and manage patient health. They are codes that represent visits rather than procedures.
Enrolled Providers	Providers for which the process of applying to a health plan or network for inclusion in their provider panels. The process often includes credentialing and contracting.
EOB	Explanation of Benefits
HCPCS	Healthcare Common Procedure Coding System: (say hick-picks). These are Level II HCPCS codes, which identify products, supplies, and services not included in CPT. HCPCS codes are five characters, consisting of one alpha character followed by 4 numeric characters.
Health Insurance Carrier	A health insurance company. Used interchangeably with health insurance company, insurer, or payer.
HIV	Human Immunodeficiency Virus
ICD-10	International Classification of Diseases, Tenth Revision. ICD-10 is the system of codes used by providers to classify signs, symptoms, illness, or injury. These codes support the medical necessity of the CPT codes, which describe the service.
Medical Policies	Plan/Payer documents that indicate clinical criteria used to support coverage determinations for specific medical, surgical, or dental procedures, devices, or medications. They may also indicate the billing format for claims to ensure information for successful coverage is communicated, i.e., CPT, ICD, and Modifiers.
Medicare Claims Processing Manual	A comprehensive reference document, published by CMS, that provides all necessary information for accurately processing and submitting Medicare claims.
Modifier	Modifiers are two-digit codes appended to the CPT or HCPCS codes to indicate that a specific set of circumstances altered a service provided.
MSN	Medicare Summary Notice - a Remittance advice or EOB for Medicare
NASTAD	National Alliance of State and Territorial AIDS Directors. NASTAD is a leading, nonpartisan nonprofit association that represents public health officials who administer HIV and hepatitis programs in the U.S. NASTAD Home Page
National Coverage Determination	A Medicare National Coverage Determination (NCD) is a nationwide policy created by the Centers for Medicare & Medicaid Services (CMS) that determines whether Medicare will cover a specific medical item, service, or drug, or if coverage will be granted, limited, or excluded. These are made through an evidence-based process with opportunities for public input. If an NCD is not available for a service, coverage is determined locally by Medicare contractors through Local Coverage Determinations (LCDs).

NCD	National Coverage Determination
Part B Medicare	Medicare Part B is medical insurance that covers outpatient and medically necessary services, including doctors' visits, diagnostic tests, preventive care like screenings and vaccines, and durable medical equipment.
Part D Medicare	Medicare Part D is an optional prescription drug benefit that helps cover the costs of brand-name and generic drugs.
Payer	A healthcare organization that provides health coverage to members. A payer will have many plans under which members are covered.
PEP	Post-Exposure Prophylaxis
plan	A specific menu of health benefits an employer, union, or other group sponsor provides to a particular group to pay for health care services.
PrEP	Pre-Exposure Prophylaxis
QHP	Qualified Health Professional
Qualified Health Professional	Per CPT, a QHP "is an individual who is qualified by education, training, licensure/ regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports (bills) that professional service."
RARC	Remittance Advice Remark Codes: Codes applied by a payer in addition to the CARC to provide more detail about the denial or adjustment. X12 RARC
Remark Codes	Codes assigned by a payer, in addition to the Denial Code, provide additional information about the claim fault.
Remittance Advice	The remittance advice (RA) is the form you get back from your Medicare claims processing contractor that lets you know whether Medicare paid in full, partially paid, or denied the items you submitted on a Medicare claim. You may receive the RA in either an electronic or paper format.
Specialty Pharmacy	A pharmacy that focuses on high-cost, high-touch, or limited distribution medications. It typically manages rare, chronic, and often complex medical conditions that require an increased level of patient management or counseling.
STI	Sexually Transmitted Infection
TAF/FTC	emtricitabine coformulated with tenofovir alafenamide (trade name Descovy®)
TDF/FTC	emtricitabine coformulated with tenofovir disoproxil fumarate (trade name Truvada®)
USPSTF	The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services. US Preventive Services Task Force

This NASTAD Billing Supplement was developed with support from Gilead Sciences.

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