CODING GUIDE

for nucleic acid amplification testing to diagnose nongenital infections with gonorrhea and chlamydia

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Background

N. gonorrhoeae (gonorrhea) and *C. trachomatis* (chlamydia) are highly prevalent bacterial sexually transmitted infections (STI). In 2015, nearly 400,000 cases of gonorrhea and more than 1.5 million cases of chlamydia were reported to the Centers for Disease Control and Prevention (CDC). Diagnosis of these infections is a marker of increased risk for HIV infection, and their presence can increase risk of both HIV acquisition and transmission. Although most gonorrhea and chlamydia infections are found among female adolescents and young adults, their incidence is also increased among men who have sex with men (MSM). Rising gonorrhea and chlamydia rates are of particular concern to MSM who are already at disproportionate risk for acquiring HIV.

Persons with HIV infection should be screened for STIs at entry into care and subsequently each year if they are sexually active. More frequent STI screening (syphilis, gonorrhea, chlamydia) at three- to six-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or their sexual partners have multiple partners.

N. gonorrhoeae and *C. trachomatis* can infect the rectum and pharynx, frequently without symptoms, where they remain undetected by common screening practices that target urethral or vaginal infection (i.e., urethral/vaginal culture or urine specimens). Asymptomatic, localized infection of the rectum or pharynx without concomitant urethral infection is not uncommon, particularly among MSM and to a lesser extent among females. Furthermore, the majority of pharyngeal and rectal infections can be asymptomatic.

To detect rectal *N. gonorrhoeae* and *C. trachomatis* and pharyngeal *N. gonorrhoeae* infections, the CDC recommends the use of nucleic acid amplification tests (NAATs) because of their superior sensitivity compared to culture, particularly for rectal and pharyngeal specimens. Although NAATs are Food and Drug Administration (FDA) cleared for genital and urine specimens, they are not FDA approved for rectal or pharyngeal specimens. Many large commercial clinical laboratories have verified their off-label use following Clinical Laboratory Improvement Act guidelines and are able to perform these tests.

Overview of Affordable Care Act and Cost Sharing

The Affordable Care Act (ACA) mandates that private health plans provide coverage for a range of preventive services and may not impose cost sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. These requirements apply to all private plans except those that existed before 2010 and have “grandfathered” status.[1] Private health plans cover screenings recommended at the A and B levels by the US Preventative Services Task Force (USPSTF). (For the most up-to-date USPSTF Grade A and B recommendations visit: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/).

For clinics providing low- and no-cost services, staff often try to estimate the cost of the visit for patients before the insurance company is invoiced. This can be a difficult task under the best of circumstances, but may be increasingly difficult when trying to ensure that patients do not incur cost sharing for preventive services. Covered services vary by payer, and clinics should make an effort to get to know the covered services of the clinic’s largest payers.

Coverage Rules

No cost sharing is imposed on patients when the visit is correctly coded as a screening and/or prevention visit

and **patients have not exceeded their annual number of allotted prevention visits.** Coverage for screening and/or preventive services is not guaranteed for all visits. Recommended preventive services may be limited to once a year by private plans. There are also circumstances, under which insurers may charge copayments and use other forms of cost sharing when paying for preventive services.[2] These include:

- If the office visit and the preventive service are billed separately, cost sharing cannot be charged for the preventive service but the insurer may still impose cost sharing for the office—problem-oriented visit itself.
- If the primary reason for the visit is not screening or prevention, patients may have to pay a co-payment or deductible for the office visit.
- If the service is performed by an out-of-network provider when an in-network provider is available to perform the preventive service, insurers may charge patients for the office visit and the preventive service. However, if an out-of-network provider is used because there is no in-network provider able to provide the service then cost sharing cannot be charged.
- If a treatment is provided as the result of a recommended preventive service, but is not the recommended preventive service itself, cost sharing may be imposed.[3]

In the cases where recommendations for preventive services and counseling apply only to "high-risk" individuals, the government clarified that it is up to the health care provider to determine whether a patient belongs to the population in consideration.

Overview of relevant reporting codes

Preventive medicine service codes

Preventive medicine service codes represent services provided to healthy individuals for the purpose of promoting health and preventing illness or injury. The "annual exam" is considered a preventive service and may include STI screening and preventive counseling. The CPT codes for annual exams are 99381–99397. In addition, there are preventive counseling codes that may be used when only guidance, advice, and recommendations are provided. The CPT codes for theses services are 99401-99404 for individual counseling and 99411-412 for group counseling.

The CPT codes 99381–99397 require an age-specific comprehensive preventive evaluation, beginning with infancy and ranging through patients age 65 and over for both new and established office patients. These codes are generally utilized by primary care providers and some specialty clinics (e.g., OB/GYN). STD clinics might not be credentialed to provide these services. Check with the clinic's contracted payers to verify eligibility to use CPT preventive medicine codes 99381–99397 (Table 1).

The key factor in using the preventive medicine codes is the absence of complaints by the patient where counseling, anticipatory guidance, and/or risk reduction are provided. The extent and focus of preventive services will largely depend on the age of the patient. By contrast you will note that the office or other outpatient CPT codes (99201–99215) include the phrase "nature of presenting problem" in their description and must include a chief complaint.

TABLE I: CPT PREVENTIVE MEDICINE CODES 99381–99397:

Age	New Patient	Established Patient
younger than one year	99381	99391
1 to 4	99382	99392
5 to 11	99383	99393
12 to 17	99384	99394
18 to 39	99385	99395
40 to 64	99386	99396
65 and older	99387	99397

Documentation requirements for a preventive visit such as an "annual physical" include an age- and gender-appropriate history and physical examination, counseling or anticipatory guidance, and risk factor reduction interventions. The preventive medicine comprehensive examination documentation requirements represent significant work for the physician or other provider, and payer fee schedules appropriately reflect that work.

Documentation must include:

- New or established
- Age
- Complete review of systems (10 or more), past medical, family and social history, and 8-organ system physical exam
- Anticipatory guidance
- Risk factor reduction

For annual physical exams, use the following Z codes.

Z01.411 Encounter for OB/GYN exam with or without PAP with abnormal findings

Z01.419 Encounter for OB/GYN exam with or without PAP without abnormal findings

Z00.00 Encounter for general adult medical without abnormal findings

Z00.01 Encounter for general adult medical with abnormal findings

Counseling codes (CPT codes 99401–99404) can be used for preventive STI counseling when there are no reported symptoms of infection. They are reported based on time. Documentation includes time spent face-to-face with a credentialed clinician and specific preventive issues discussed. Corresponding ICD-10- codes should only include prevention and screening codes, starting with the letter Z. However, coverage and reimbursement for these services can depend on the type of provider submitting the claim, the procedure/service and diagnosis codes submitted, and the patient's contract with the insurance company. Checking with each specific insurance payer is encouraged before initiating any extensive preventive service.

Counseling CPT codes do not include immunizations and ancillary studies involving laboratory, radiology, or other procedures that are reported separately and are not used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness.

TABLE 2: COUNSELING CODES 99401-99404

Code	Time
99401	15 minutes
99402	30 minutes
99403	45 minutes
99404	60 minutes

CPT code 99411 and 99412 are for group interventions:

99411 Preventive medical counseling and/or risk factor reduction intervention-group; 30 minutes

99412 Preventive medical counseling and/or risk factor reduction intervention-group; 60 minutes

Group interventions (counseling) are rarely reimbursed by government or private payers. Check with your payers before adding this services to your delivery line.

Evaluation and management service codes

The Centers for Medicare and Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines for Evaluation and Management Services divide documentation for evaluation and management (E/M) codes into three key components: history, exam, and medical decision making. The appropriate office/outpatient codes 99201–99215 may be reported if the patient presents with any complaint, an abnormality is encountered, or a preexisting problem is addressed in the process of performing a preventive medicine service. For new patients (99201-99205), the minimum of all three key components is required for the code. For established patients (99211-99215), only two of the three key components must meet or exceed criteria to qualify for a specific level of E/M service.

If an E/M visit is conducted in addition to a prevention service, CPT modifier 25 should be added to the CPT office/outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service. When this type of coding scenario is utilized, it is recommended that the provider document two separate notes, so that it is evident that the E/M service is over or above what would have been provided in the preventive exam. Alternatively, the provider may opt not to use the preventive counseling code and indicate that the main purpose of the E/M visit is screening or preventive in nature by appending the CPT modifier 33 to it (private payers only). Be sure that the ICD-10 code lists a screening Z code first when documenting the ICD-10 codes.

TABLE 3 : CPT EVALUATION AND MANAGEMENT SERVICE CODES 99201–99215 BY HISTORY, EXAM, AND LEVEL OF MEDICAL DECISION MAKING (MDM)

NEW PATIENT	
Code	**Description**
99201	Problem focused with straightforward MDM
99202	Expanded problem focused with straightforward MDM
99203	Detailed with low MDM
99204	Comprehensive with moderate MDM
99205	Comprehensive with high-complexity MDM

ESTABLISHED PATIENT	
Code	**Description**
99211	Clinician not required
99212	Problem focused with straightforward MDM
99213	Expanded problem focused with low MDM
99214	Detailed with moderate MDM
99215	Comprehensive with high-complexity MDM

Another option for E/M encounters is to use time as your guide. **If counseling or coordination of care account for more than 50 percent of the visit, then you can select your E/M code based on the length of the visit.** In general, the time spent counseling should meet or exceed the typical visit times listed. If you decide to use time-based billing, make sure to document the time in your chart (e.g., "9:01–9:18 a.m., 10 of 17 minutes spent counseling patient on safer sex practices").

TABLE 4 : CPT EVALUATION AND MANAGEMENT SERVICE CODES 99201–99215 BY TIME

NEW PATIENT	
Code	**Time**
99201	10 minutes
99202	20 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes

ESTABLISHED PATIENT	
Code	**Time**
99211	5 minutes
99212	10 minutes
99213	15 minutes
99214	25 minutes
99215	40 minutes

Laboratory CPT Codes

If the clinic uses a commercial laboratory to process its chlamydia and gonorrhea specimens and the lab bills for the service, the clinic cannot also bill for the service. However, the clinic may want to track the labs that have been ordered by CPT code.

CPT Code	Description
87591	Neisseria gonorrhea detection by nucleic acid, amplified probe technique for genital, rectal and throat specimens
87491	Chlamydia trachomatis, detection by nucleic acid amplified probe technique for genital, rectal, and throat specimens

SELECTED STI SCREENING PREVENTIVE ICD-10 Z CODES

ICD-10 Code	Description
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission (for chlamydia or gonorrhea, not HIV or human papillomavirus)
Z11.8	Encounter for screening for other infectious and parasitic diseases (screening for chlamydia or syphilis, not gonorrhea)
Z11.4	Screening for HIV
Z11.89	Counseling for other problems related to lifestyle **Other possible codes to consider:**
Z72.51	*High-risk sexual behavior (heterosexual)*
Z72.52	*High-risk behavior (homosexual)*
Z72.53	*High-risk behavior (bisexual)*
Z00.00	Encounter for adult medical exam without abnormal findings
Z00.01	Encounter for adult medical exam with abornmal findings
Z01.411	Encounter for gynecological exam (with or without Pap) with abnormal findings
Z01.419	Encounter for gynecological exam (with or without Pap) without abnormal findings
Z20.2	Contact with and (suspected) exposure to venereal diseases; exposure to disease that is predominantly sexually transmitted

Basic coding strategy for nongenital gonorrhea and chlamydia testing

Many patients with high-risk behaviors warranting nongenital gonorrhea and chlamydia testing also require substantial office visit time dedicated to counseling. In addition, high-risk patients presenting for routine screening or preventive health visits may also receive specific medical services, such as substance abuse counseling and referral. For time spent with complex patients, clinicians must maintain careful records of all the problems addressed in the visit, total time spent with a patient, total time spent in counseling or care coordination, and a summary of issues discussed. Diagnostic codes listed must include all the issues addressed. Proper documentation of the visit is essential to qualify reporting any appropriate level E/M code.

With high-risk patients, most of the visit is often spent counseling rather than examining or performing a procedure. When time spent in counseling and/or care coordination is more than 50 percent of face-to-face time, clinicians may use an E/M code. Code choice is based on total visit time. Time spent counseling should be clearly documented. For example, in a scenario where a clinician spends 25 minutes face-to-face with an established patient, and 15 minutes of that visit was spent in counseling regarding the patients diagnosis of chlamydia, treatment, and prevention of recurrence, the clinician may use time to select the E/M service since more than 50 percent of the visit was spent counseling. In this example, the clinician could report E/M code 99214 for a 25-minute visit. If the counseling is initiated because an STI is present or is being ruled in or ruled out with pending lab work due to symptoms, then the visit is not considered preventive: CPT codes 99201-99215 should be used.

Alternatively, in the example above, if it is unknown at the time of the visit if chlamydia is present, the clinician could code the visit as counseling related to STI prevention and use CPT codes 99401-99404. However, not all payers reimburse for prevention counseling codes (99401–99404). Some payers, however, will reimburse the E/M CPT codes billed with the modifier 33 (private payers only) to indicate the visit it is a preventive service.

In the event a problem-oriented service or procedure was performed as a result of an abnormality identified during the preventive visit (annual exam CPT codes 99381–99397), the extra work associated with that abnormality or preexisting condition (i.e., above and beyond the work of the preventive medicine visit) should be reflected in an additional E/M code. It is recommended that the provider create a separate, stand-alone note to reflect this additional work. The CPT modifier 25 should be appended to the appropriate level office E/M code to indicate that a significant, separately identifiable E/M service was performed in addition to the preventive medicine visit. Remember, the E/M codes (99201-99215) will be subject to cost sharing by the patient.

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1 http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/

2 Ibid.

3 Ibid.

Specific examples

EXAMPLE 1: SUSPECTED EXPOSURE TO STI

A 34-year-old single male attorney who reports to the walk-in clinic requests an asymptomatic STI screen since he engages in unprotected, receptive, and insertive anal and oral sex with men. The nurse practitioner (NP) provides 15 minutes of STI prevention counseling, swabs of mucosa of rectal and pharyngeal surfaces are collected, as well as a urine sample, for a gonorrhea and chlamydia NAAT, and orders the following tests to be drawn in the clinic phlebotomy station and sent to a commercial lab: serum HIV antibody test, HIV RNA by PCR, RPR.

ICD-10-CM (clinically modified) diagnosis codes

Z71.7 HIV counseling

Z71.89 Other specified counseling; (counseling on STIs)

Z77.21 Personal history of contact with and suspected exposure to potentially hazardous body fluids

Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission

Z11.4 HIV screening

Z72.52 High-risk homosexual behavior

CPT codes

99401 Office service. Preventive counseling.

36415 Collection of venous blood by venipuncture. Should also be reported as appropriate. If blood collection by venipuncture is performed by the office or clinic staff and the specimen is then sent to an outside lab, it should be reported. If the outside or contracted lab personnel draw the specimen, it should not be reported by the clinic or the office. This code represents a nominal fee and a nominal reimbursement. It is not always paid by third party payers.

NOTE: There are no specific CPT codes for pharyngeal and anal specimen collection.

The NP also includes all of the above ICD-10-CM codes on the lab form that he or she submits to the phlebotomy station.

EXAMPLE 2: HIV-POSITIVE PATIENT

A 34-year-old male who is an established patient with HIV infection on stable combination antiretroviral therapy, with recent CD4+ T-cell count of 525 and an HIV viral load below the limit of detection, is seen on follow-up at his HIV care clinic. He reports no STI-associated symptoms. Given his five male sex partners in the prior six months and variable use of condoms, comprehensive STI screening for syphilis, gonorrhea, and chlamydia is performed at this visit. Based on the patient's specific sexual behaviors, swabs of mucosa of rectal and pharyngeal surfaces are collected, as well as a urine sample, for a gonorrhea and chlamydia NAAT; the patient is screened for syphilis by serum RPR. Four days later, the patient returns for follow-up of a positive rectal chlamydia NAAT (with remainder of screening tests negative). He is treated with doxycycline 100mg orally twice daily for seven days. On this second visit the clinician spends 20 minutes counseling on medication use, potential exposure of recent sex contacts, and modification of behaviors to decrease risk of future STI exposures. The patient is provided medication for treatment of two partners. Per CDC recommendations, the patient returns in three months for re-screening for chlamydia and counseling. The total visit time is 25 minutes, including 15 minutes of counseling. Testing for this and other STIs is negative following this third visit.

First visit

ICD-10-CM diagnosis codes

Z21 Asymptomatic human immunodeficiency virus (HIV) infection status (this must go first, as order matters for ICD-10 codes)

Z72.52 High-risk sexual homosexual behavior or Z72.89 Other problems related to lifestyle

Z71.89 Other specified counseling (STI risk-reduction)

Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission

CPT codes for first visit

99214 Office service (established patient). Appropriate office visit code from the office or other outpatient series code series for an established patient based on the key components performed in the process: history, exam, and medical decision making

Second visit (follow-up treatment)

ICD-10-CM diagnosis codes

A56.3 Chlamydial infection of anus and rectum

Z21 Asymptomatic HIV infection status

Z71.89 Other specified counseling (STI risk reduction)

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm (STD follow-up exam)

Z72.52 High-risk sexual homosexual behavior or **Z72.89** Other problems related to lifestyle

CPT codes

99214 Office service. For the E/M of an established patient if the test(s) are positive and counseling is provided. When counseling and/or coordination of care dominates (more than 50 percent), the physician/patient and or family encounter (face-to-face time in the office or other outpatient setting), time is considered the fundamental factor to qualify for a particular E/M service level. Since counseling was documented as 20 minutes of the 25-minute visit, 99214 may be appropriate. The extent of counseling and coordination of care must be documented in the medical record.

Third visit

ICD-10-CM diagnosis codes

Z71.89 Other specified counseling (STI risk reduction)

Z21 Asymptomatic HIV status

Z72.52 High-risk homosexual behavior

Z72.89 Other problems related to lifestyle

Z86.19 Personal history of other infectious and parasitic diseases

Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission

CPT codes

99401 Office service. Preventive counseling

EXAMPLE 3: PATIENT WITH COMPLAINT

A 19-year-old unmarried male who is an established patient presents to the ambulatory clinic for complaints of hemorrhoids for one week. The patient reveals a four-year history of unprotected receptive anal intercourse with multiple male partners and denies any other oral or genital sexual acts. Physical exam is consistent with non-ulcerative proctitis. Blood specimens are collected by venipuncture for syphilis (RPR) and HIV (HIV antibody and HIV RNA by PCR), and a rectal specimen for a gonorrhea and chlamydia NAAT. The patient is empirically treated for proctitis with a ceftriaxone 250 mg intramuscular injection and a prescription for azithromycin 1 gram, and provided counseling for 15 minutes on medication and disease. The total visit time was 25 minutes. On second visit seven days later, the patient is informed that his rectal gonorrhea test is positive and the other tests were negative. The patient was provided counseling for 20 minutes on his disease and STI prevention, and blood was drawn to test for infection with viral hepatitis B and C virus (HBsAg, HCV Ab) and for herpes simplex virus (HSV), using type-specific antibody testing for types I and II.

First visit

ICD-10-CM diagnosis codes

K62.89 Other specified counseling

CPT codes

99214 Office service. Office visit code from the office or other outpatient series code series for an established patient based on the key components performed of E/M, including treatment and 15 minutes of counseling.

36415 Test administration. Collection of venous blood by venipuncture. Should be reported for collection of venous blood by venipuncture

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular, should be reported for the therapeutic injection of ceftriaxone sodium 250 mg, IM

J0696 Injection, ceftriaxone sodium, per 250 mg

Second visit

ICD-10-CM diagnosis codes

A56.3 Chlamydial infection of anus and rectum

A54.6 Gonococcal infection of anus and rectum

CPT codes

99213 Office service. Since 20 minutes of the 20-minute visit was counseling face-to-face, use an appropriate level code from the 99211–99215 series for the E/M of an established patient if the test(s) from the previous visit are positive and counseling is provided. Again, the appropriate office E/M codes for new or established patients may be used to report counseling of individual patients with symptoms or established illness. In this specific clinical scenario, the E/M code is reported to reflect the counseling and coordination of care due to the positive test results.

All visits

CPT code

36415 Collection of venous blood by venipuncture. Should also be reported as appropriate. If blood collection by venipuncture is performed by the office or clinic staff and the specimen is then sent to an outside lab, it should be reported. If the outside or contracted lab personnel draw the specimen, it should not be reported. Note: There are no specific CPT codes for pharyngeal and anal specimen collection.

EXAMPLE 4: MINIMIZING COST SHARING

A 25-year old female receives a chlamydia screening test and counseling (recommended preventive service) during an office visit at a family planning clinic for irregular menses.

When only a preventive CPT code and the supporting ICD10 screening codes (generally start with the letter Z), are present on a claim, and the patient has not previously used his/her preventive services allowed by the payer, there is no cost sharing for the patient. Some payers impose a flat rate co-payment (for example: $20 per office visit) or a percentage of the visit (20% of the reimbursement of the billed CPT code).

However, this patient presented to the clinic with a problem not solely a request for screening.

The health plan will likely impose cost sharing requirements for this office visit because both types of IC-10 codes are used on the claim.

NOTE: There are two ways to code the services for this patient. It will depend on the patient's plan as to how much cost sharing she will incur.

Coding scenario 1 (co-payment flat rate or 20% of 99214)

ICD-10 Codes

N92.6 Irregular menses

Z71.89 Other specified counseling

Z11.8 Screening for chlamydia

CPT Codes

99214 Office visit. Code from the office or other outpatient series code series for an established patient based on the key components performed of E/M, including treatment and 15 minutes of counseling

Coding scenario 2 (co-payment flat rate or 20% of 99213)

This scenario requires two different sets of ICD-10/CPT code groups.

N92.6 Irregular menses

with

99213 (25 modifier) office visit code from the office or other outpatient series code series for an established patient based on the key components performed of E/M

AND

Z71.89 Other specified counseling

Z11.8 Screening for chlamydia

with

99401 15 minutes preventive STI counseling

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