



State of New Jersey  
 Department of Human Services  
 Division of Medical Assistance & Health Services

# NEWSLETTER

Volume 14 No. 5

January 2004

## REVISION OF NEWSLETTER VOLUME 13 NO. 71

**TO:** Independent Clinical Laboratories and  
 Hospital Based Laboratories - **For Action**  
 Health Maintenance Organizations - **For Information Only**

**SUBJECT:** New Healthcare Common Procedures Coding System (HCPCS)  
 Codes for Antiretroviral Resistance Testing:  
 Genotype, Phenotype and Virtual Phenotype

**EFFECTIVE:** For dates of service on or after November 1, 2003

**PURPOSE:** To rescind Vol. 13 No. 71 and notify Independent Clinical Laboratories and Laboratory Providers that as of November 1, 2003, the New Jersey Division of Medical Assistance and Health Services (DMAHS) will reimburse for Antiretroviral Resistance Testing, and to clarify that **reimbursement is limited to three tests per 12-month period.**

For example, one Genotype **and** one Phenotype test performed during a rolling 12-month period **plus** another Genotype **or** Phenotype test performed during the same period would represent a total of three (3) tests. The Phenosense GT Resistance Test, performed by Virologic, represents **two (2) tests.**

**ACTION:** **This newsletter supercedes Vol. 13 No. 71. Please destroy Volume 13 No. 71 and replace it with this newsletter.** For claims with dates of service on or after November 1, 2003, the New Jersey Medicaid program and NJ FamilyCare (NJFC) fee-for-service programs will reimburse a Clinical Laboratory provider for the following Antiretroviral Resistance Testing:

HCPCS CODE	DESCRIPTION	MAXIMUM FEE ALLOWANCE
87901	Genotype	\$350.00
87999	Virtual Phenotype (Ordered with 87901 Genotype)	\$80.00

**NOTE:** This is a temporary procedure code. Laboratories will be advised further regarding the billing of "0023T" for this service.

87903	Phenotype (First ten drugs tested)	\$675.72
87904	Phenotype (each additional up to 5 drugs tested) (List separately in addition to the primary procedure code, must be utilized in conjunction with 87903)	\$36.00

**Reimbursement for each test is limited to three per year (12 month period).** Please contact Phyllis Valeri-Bruschini, M.T., Laboratory Consultant, at 609-588-4610 to request an exception to this limitation.

Attached to this newsletter is the Antiretroviral Testing Checklist Criteria. The completed criteria checklist **MUST** be kept with the beneficiary's medical record.

Education is a critical component of this initiative to provide DMAHS coverage for Antiretroviral Testing. Educational seminars will be offered by Fisher Medical Communication, in co-sponsorship with New York and New Jersey AIDS Education Training Center (New Jersey local performance site), and the University of South Florida College of Medicine, in cooperation with the University of Medicine and Dentistry of New Jersey (UMDNJ) and the New Jersey Medicaid Program.

It is strongly recommended that Medicaid providers attend one of these educational seminars. The seminars will be provided throughout the State of New Jersey in March and April of 2004. Seminar dates will be announced to laboratory providers through Fisher Medical Communication.

If you have any questions or concerns please contact Phyllis Valeri-Bruschini, M.T., Laboratory Consultant, Division of Medical Assistance and Health Services, at (609) 588-4610.

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**State of New Jersey  
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**ANTIRETROVIRAL RESISTANCE TESTING CHECKLIST OF CRITERIA**

**TO BE KEPT WITH THE BENEFICIARY'S MEDICAL RECORDS**

**Medicaid Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The above patient is under my medical care and needs to have a resistance test. I am ordering the test for the following reason:

**Adult Patients:**

\_\_\_\_\_The patient is on antiretroviral therapy (ART) and is virologically failing the regimen as defined in New Jersey Medicaid's Antiretroviral Resistance Testing Standards.

\_\_\_\_\_The patient has a sub-optimal virologic response after the initiation of ART as defined in the Guidelines.

\_\_\_\_\_The patient has acute HIV infection (i.e., infection < 6 months).

\_\_\_\_\_The patient is pregnant.

\_\_\_\_\_Other:

**Pediatric Patients:**

\_\_\_\_\_The patient is a newly infected: \_\_\_ infant \_\_\_ child \_\_\_ adolescent.

\_\_\_\_\_The HIV RNA has not decreased as expected within 4 to 6 months of initiating HAART, or when there is viral rebound as described in the Guidelines.

\_\_\_\_\_Other: \_\_\_\_\_

**The patient has demonstrated good adherence to the antiretroviral regimen and there is documentation of this in the patient's medical record.**

**Test to be ordered:** \_\_\_ Genotype \_\_\_ Phenotype \_\_\_ Virtual Phenotype

**Date of last resistance test:** \_\_\_ / \_\_\_ / \_\_\_

**Type of test previously ordered:** \_\_\_ Genotype \_\_\_ Phenotype \_\_\_ Virtual Phenotype

**Signed:** \_\_\_\_\_

**New Jersey License Number:** \_\_\_\_\_

**New Jersey Medicaid Number:** \_\_\_\_\_