Human Immunodeficiency Virus (HIV) Prevention and Linkage to Care Reporting

This resource provides essential guidance for health centers on accurately reporting HIV Pre-Exposure Prophylaxis (PrEP)-associated prescribing and management (Table 6A, Line 21e), HIV tests (Table 6A, Line 21), HIV Screening (Table 6B, Line 20a), and HIV Linkage to Care (Table 6B, Line 20), and in the Uniform Data System (UDS). Accurate documentation and coding are critical to ensure reliable data.

Pre-Exposure Prophylaxis (PrEP)

Table 6A, Line 21e, captures the number of patients prescribed PrEP, and their related prevention visits (initiation, medical management – such as regular labs and prescription refills) provided by licensed or credentialed medical, dental, mental health, substance use disorder, or vision providers.

Health centers must limit the reporting of Line 21e to patients **prescribed PrEP based on a patient's risk for HIV exposure** AND limited to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF), emtricitabine/tenofovir alafenamide (FTC/TAF), cabotegravir, or lenacapavir for the purposes of preventing HIV. ICD-10-CM code Z29.81 should be used to identify PrEP prescribing and management for health center patients. Do not report patients with a **diagnosis of HIV** concurrent with a prescription for FTC/TDF, FTC/TAF, cabotegravir, or lenacapavir on Table 6A, Line 21e, as that indicates the prescription is part of HIV or other related treatment, as opposed to HIV prevention.

ICD-10 code Z29.81, *encounter for HIV pre-exposure prophylaxis,* is to be used for reporting this line. If the health center is not using this code, then only services that are equivalent to this code, and reflect HIV PrEP prescribing and management specifically, should be reported on this line.

Note: To avoid overcounting and to ensure reasonableness on this line, cross-check the counts prior to reporting with the America's HIV Epidemic Analysis Dashboard, which provides state- and territory-level counts of individuals prescribed PrEP.

HIV Screening

Table 6B, Line 20a, captures patients between 15 and 65 years old who were tested for HIV when they were in the age range.

It is important to understand the relationship between HIV screening reported on Table 6B, Line 20a, and HIV tests reported on Table 6A, Line 21. The HIV Screening measure on Table 6B reports the number of patients aged 15–65 who had no prior HIV diagnosis before the measurement period, were seen during the calendar year, and have documentation of an HIV test performed between their 15th and 66th birthdays (regardless of when the test occurred or

who performed the test). Whereas the Table 6A HIV test line is health center patients of any age who received an HIV test at the health center (performed, paid, or evaluated) during the calendar year. For this reason, it is unlikely that HIV tests reported on Table 6A will be larger than those reported on Table 6B.

Note: Use the codes listed on Table 6A, Line 21, to ensure proper coding and capture of HIV tests performed by the health center during the calendar year. Use CMS349v8 to capture and report the HIV Screening clinical quality measure (CQM), as specified by the measure steward.

HIV Linkage to Care

Table 6B, Line 20, captures the extent to which patients who are newly diagnosed with HIV by the health center are seen for follow-up treatment within 30 days of diagnosis. The HIV Linkage to Care CQM does not have an associated electronic specification, and the UDS Manual does not include specific codes to identify patients as being newly diagnosed.

There are NO specific codes to identify a patient as being **newly diagnosed** with HIV. A set of ICD-10-CM and value set object identifier (OID) codes (may not be all-inclusive) are provided below that may be used only as a starting point for identifying patients with symptomatic or asymptomatic HIV diagnosis. **Identification of patients for the denominator of this measure must be further limited to those who are newly diagnosed with HIV by a health center provider.**[1]

- **ICD-10-CM:** B20, B97.35, Z21
- **OID:** 2.16.840.1.113883.3.464.1003.120.11.1007, 2.16.840.1.113883.3.464.1003.120.11.1010

Note: The codes or value set listed above are not sufficient ALONE for identifying the denominator for this CQM, as they are not limited to **newly** diagnosed HIV.

To specifically identify newly diagnosed HIV patients, ensure that the "date diagnosed" and "onset date" are accurately documented in the health information technology/electronic health record.

- The "date diagnosed" should be used only if it represents patients newly diagnosed with HIV.
- Accurate "onset date" documentation is crucial to exclude patients previously diagnosed elsewhere from being incorrectly counted as newly diagnosed.

To include the patient in the assessment (Denominator):

- Patient identification may span multiple years and include prior-year patients since patients had at least one visit during the measurement period and were diagnosed with

[1] Patients newly diagnosed with HIV is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.

HIV for the first time ever by the health center between December 1 of the prior year and November 30 of the calendar year are included.

- Reactive initial HIV tests and self-reported HIV positivity require a confirmatory supplemental test.
- DO NOT include patients who:
  - Were diagnosed elsewhere, even with documentation.
  - Had a reactive screening test without a positive supplemental test.
  - Had a reactive screening test given at the health center but were sent elsewhere for definitive testing and treatment.

To count as linkage to care (Numerator):

- **Treatment**—NOT merely a referral, education, or retesting—**must begin** within 30 days of the HIV diagnosis. Include patients in the numerator only if HIV care was initiated within this 30-day window.
- For patients treated by referral (e.g., to a Ryan White provider), treatment must begin within 30 days, and documentation from the referral provider confirming treatment and visit date is required.