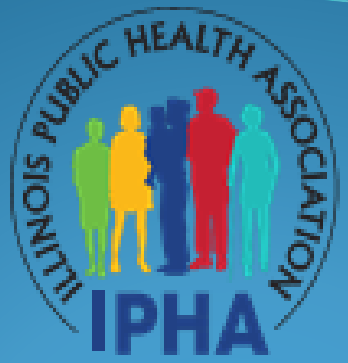


Illinois Public Health Association

Credentialing, Contracting, Coding and Billing for Public Health HIV Services

Shefali Mookencherry, MPH, MSMIS, RHIA, CHPS, HCISPP

Presenter

December 15, 2017

- This webinar is being provided by the HIV Category B Third Party Billing and Reimbursement Project.

- This project is funded by a grant from the Centers for Disease Control and Prevention (CDC) and the Illinois Department of Public Health.

- The HIV Category B Third Party Billing and Reimbursement Project is a collaborative effort with the Public Health Institute of Metropolitan Chicago (PHIMC).

Presenter Introduction

- **Shefali Mookencherry, MPH, MSMIS, RHIA, CHPS, HCISPP**

  Shefali Mookencherry has extensive experience in healthcare policy, public health reimbursement/revenue cycle, HIPAA, healthcare IT/finance, IT security, MACRA, and Meaningful Use, including 25+ years in the healthcare industry, with nine spent in senior management positions.

  Furthermore, Shefali teaches graduate students at a local University about HIPAA, health insurance exchanges, revenue cycle, healthcare reform, and IT security.

Online Training Series

Medical Coding and Billing for Public Health Services

IPHA is proud to offer a new online training series entitled **Medical Coding and Billing for Public Health Services.** This unique training series includes 16 online classes covering all aspects of medical coding and billing for public health services. The courses were designed and presented by Shefali Mookencherry, MPH, MSMIS, RHIA, CHPS, HCISPP.

These courses are currently available on the University of Illinois at Chicago's (UIC) Public Health Learning website:

https://www.publichealthlearning.com/course/index.php?categoryid=42

Assumptions

- Certain information in this presentation comes from a variety of sources such as:
  - CMS (their website cms.gov)
  - Illinois General Assembly (Public Acts/legislation)
  - Illinois Department of Healthcare and Family Services (HFS)
  - Managed Care Payers
  - Industry blogs, journals, etc.

Disclaimer: *The materials for this presentation are for informational purposes only. Information on this topic does not constitute legal or business advice. Information in this presentation is provided without warranty of any kind, either expressed or implied, including but not limited to, the implied warrantees of fitness for a particular purpose. Many policies, procedures, and codes will vary based on individual departments, services offered, and individual situations. It is the responsibility of every local health department to verify information as it pertains to their own individual department.*

Objectives

- Develop an understanding of credentialing, contracting, coding and billing processes for Public Health HIV Services
- Understand key terminology related to credentialing, contracting, coding and billing for Public Health HIV Services
- Review key steps to take for credentialing, contracting, coding and billing for Public Health HIV Services
- Understand documentation requirements for credentialing, contracting, coding and billing for Public Health HIV Services

AIDS/HIV Credentialing

AIDS/HIV Services

- Screening/Evaluation
- Testing
- Diagnosis
- Counseling
- Treatment

AIDS/HIV Providers

- Physician
- Nurse practitioner
- Physician assistant
- Peer counselors certified as Community Health Workers
- Community based organizations
- HIV laboratories

Delivery Models

- Local health department.
- Local health department partnering with community based organization(s) or individual physicians and other clinicians.
- Local health department partnering with laboratories.

Note: Some payers may categorize local health department clinics as “Rural health clinics”.

Agreements

- Contract
- Letter of intent
- Memorandum of Understanding (MOU)
- Enrollment

Note: Some payers will have one or combination of the above as part of credentialing process.

Provider Enrollment

- Think of the combined process of credentialing and contracting as ENROLLMENT.
- Enrollment encompasses the entire process of gaining eligibility to receive reimbursement from a third-party payer.
- **CREDENTIALING + CONTRACTING = ENROLLMENT**

Credentialing by Payers

- Not Required
  - Self Pay
  - Worker's Compensation (WC)
- Required
  - Private (commercial) insurance
    - Group & Individual Plans
      - Examples (e.g. BCBS, Aetna, Cigna)
  - Government insurance
    - Medicare (CMS)
    - Medicaid/Child Health Plan
    - TriCare

What is Credentialing?

- A process in which detailed information related to a provider is gathered and submitted for approval.
- During credentialing, the payer reviews, validates, and finally approves demographic, educational, professional licensure, and other pertinent information.
- Payer grants the provider approval and permission to then contract with the payer if desired.

Key Credentialing Steps

- Register clinicians with the Council for Affordable Quality Healthcare's (CAQH) – Universal Provider Datasource (UPD).
  - May not be necessary if payer only requires group National Provider Identifier.
- Review payer mix to see who you should contract with.
- Contact payer to verify contract is in place or if new contract needs to be established.
- Locate payer website and search for "provider contracting" or "provider relations".

Key Credentialing Steps (continued)

- Review payer credentialing process.
- Submit application and documents.
- Payer will validate/verify information submitted.
- Follow up on status.
- Payer will provide “Date Effective” participation approval letter.

Note: It is assumed that the LHD has developed credentialing policies, which provide guidance on these steps.

Credentialing Policies

- Local health departments should have the following policies written and educate staff on:
  - List name of designated individual who will do the credentialing, authorized signer, and that person's back up
  - Confidentiality statement for person who is doing the credentialing. (Have person sign it for compliance with HIPAA)
  - List of HIV services provided by local health department clinic
  - List of contracted payers and provisions for HIV services
  - List of community based organizations and contact information
  - Credentialing tracking workbook

Who Should Credential…at LHD

- Deciding who will be responsible for your LHD credentialing is important. Due to the sensitivity and the confidential nature of the information needed to credential, careful consideration should be given.
- It is suggested that the person who starts the process, finish it through to completion.
- Some payers will allow the provider to designate an authorized signer. This individual will have the ability to make changes to the provider's enrollment.

When and Why to Credential

WHEN?

- Do you plan to begin seeing patients and billing? Contingent upon this fact is when you should begin your credentialing process.
  - In general, most enrollments can be complete within 90-120 days from submission of your application;
  - However most payers reserve a greater amount of time to complete the process. Be optimistic but plan for the worst.
  - TIP: Ask the payer what their timelines are for processing enrollment applications and remind them if necessary.

WHY?

- FOCUS ON THE GOAL! Credentialing and contracting can be exhausting and frustrating- keep your eye on the prize and stay persistent!

LHD Credentialing…

- Many LHDs are facing challenges in credentialing with private payers due to the fact that there is not an onsite or actively participating MD/DO.
- Please note that most often if a Medical Director (Physician) is actively practicing elsewhere then he/she is receiving payment and is *already credentialed with the private payers*.
- It would NOT be necessary for an LHD to complete an entire Credentialing Application for the clinician or physician. With the permission of the clinician or physician, the LHD would need to request the addition of their practice location (the LHD) to the clinician's or physician's enrollment.

Credentialing Documentation and Information Needed

Health Care Professional Credentialing and Data Collection Act

- (410 ILCS 517)
- The Health Care Credentials and Data Collection Act requires uniform forms to be utilized in order to collect the credentials data commonly requested by health care entities and health care plans for purposes of credentialing and recredentialing.

Typical Credentialing Documents

- IRS document showing legal name and confirming Tax ID CP 575 IRS 147 C
- State License to practice
- Professional School Diploma
- Undergraduate Diploma
- Board Certificates
- Internship and Residency Certificates, Fellowship too
- Photocopy of License/ID
- DEA Certificate

Typical Credentialing Documents (continued)

- National Provider Identifier: Individual and Organizational Username and PWs for National Plan and Provider Enumeration System (NPPES)
- Any final adverse actions? Sanctions? Legal documentation/court dispositions? Anything they cannot get from State Medical Board site Applies to Authorized Officials as well.
- Copy of lease/utility bill
- EFT Agreement (mandatory?) Voided Check/Bank Letter
- CLIA Certificate if applicable

National Provider Identifier (NPI)

- 10 digits
- https://nppes.cms.hhs.gov
- Individual = Type 1
- Organizational = Type 2
- If you wish to enroll as a group/org, you will need a type 2 NPI prior to applying (varying turnaround)
- Issued once; never expires or changes
- NPI registry (NPPES) accuracy is IMPORTANT-- SS#, DOB, Name spelling Systems talk to each other (SS PECOS MCS)
- Taxonomy chosen when you first get an NPI number, i.e.: specialty driven Mass Immunizer = 251Kooooox (public health only)

To Avoid Lapses in Credentialing

- Designate a person to be responsible for the credentialing.
- Create and maintain a file for each provider. If a provider covers multiple locations, each location needs to be part of his/her profile. For NPs and PAs, depending on the state, there may be collaborative agreements specific to each location.
- It is important to manage the document expiration cycle so provider documents are always current. The Provider Credentialing Tracking Workbook can help track document expiration dates and renewals.
- Remind providers to forward updated credentialing documents to the credentialing administrator 60 days prior to when the documents expire.

Reasons for Returned Forms

- No signature
- Incorrect version
- Copied application
- Stamped signature
- Signature not dated
- Failed to submit required forms
- Completed in pencil
- Applicant submitted wrong application
- Application received more than 30 days prior to the effective date

AIDS/HIV
Payer Contracting

What is Contracting?

- A process of establishing an agreement between health care providers and health plans.
- Details:
  - Services to be provided
  - Payment rates
  - Filing timelines
  - Other obligations between each party
- Negotiating a contract may take 60 to 120 days.
- Contracts are not guaranteed.

HIV Payer Contracting Key Terminology

Basic Terms

- Contract period
- Insurance coverage and indemnity
- Dispute resolution
- Advance notice of changes in terms
- Breach
- Renewal
- Termination
- Beneficiaries

Services Terms

- Covered services
- Definitions
- Non-covered services
- Formulary

Service Terms (continued)

- Provider/practitioner choice and changes
- Clinician credentials
- Referrals
- Medical necessity prior to authorization
- Access standards

Payment Terms

- Claims submission
- Clean claims
- Payment methods
- Payment amount
- Payment timing
- Under and over payments
- Recoupment
- Dispute resolution

Provider Participation Agreement

Benefits to Local Health Departments/Clinics:

- Participating Providers (PAR) are healthcare providers who have entered into an agreement with an insurance carrier.
  - Insurance companies screen providers to insure they meet certain standards of quality.
  - Insurance carriers agree to direct clients to the provider and in exchange, the provider accepts a lower fee for services. (In-Network)

Provider Participation Agreement

- Non-participating Providers (non-par) are healthcare providers who have declined or denied entering into a contract with an insurance company.
  - Sometimes the fee offered by the insurance company is less then your LHD is willing to accept. (Out-of-Network)

Benefits to Patients:

- In-Network provider have lower co-pays and protect from having to pay for services that are not considered medically necessary (pay fees which are above what is usual and customary).
- Out-of-Network providers may have lower fees for special events or other discounts.

Inform Payer Contracting Team…

- AIDS/HIV Services provided by local health department/clinic
  - Screening/Evaluation
  - Testing/labs
  - Diagnosis
  - Counseling
  - Treatment/Medications
- HIV related terms
- HIV care continuum
- Clinical staffing model
- Visit frequency and duration

Inform Payer Contracting Team…

- Formulary adequacy
- Preventive, clinical, care management, and other services offered
- Adequacy of payment models

HIV Payer Contracting Key Steps

Key Contracting Steps

- Determine the third-party payers with which you want to contract.
- Collect information about contracting with particular insurance companies.
- Initiate contact with insurance company.

Key Contracting Steps (continued)

- Obtain NPI (National Provider Identifier) numbers for the practice and clinicians.
- Credential your clinicians and locations.
- Complete the application and or other agreements as determined by payer.

Key Contracting Steps (continued)

- Review the terms and rates of the contract.
- Negotiate any objectionable condition.
- Sign contract.
- Keep contract on file for renewal and annual updating of fees.

Key Contracting Steps (continued)

- Review terms for:
  - Balance Billing - occurs when the LHD bills the client for the difference between what they charge and the health insurance allowable amount.
    - Some contracts between insurers and LHDs do not allow providers to balance bill. A provider who "Accepts Assignment" agrees not to balance bill patients.

Key Contracting Steps (continued)

- Review terms for:
  - Fee-for-Service insurance - seldom pays 100% of what providers charge.
    - The "Allowable Amount" is the price that an insurance company will pay for a specific service.
      - This amount is based on a negotiated "Fee Schedule."
      - Sometimes it is based on the "Usual and Customary Charge" for providers in a given geographic area.

Documentation and Information Needed For HIV Contracting

Documentation Needed

- Documents might include:
  - The State Medicaid MCO model contract
  - The RFP summarizing the MCO's contractual obligation s and the terms to be passed to providers
  - Draft contract between the MCO and your local health department/clinic and/or Community Based organization/provider
  - Exhibits
  - Referenced documents

Documentation Needed

- Documents might include:
  - Agency Certifications and Licensure – W-9, Liability Insurance, CLIA Certificate
  - Provider Numbers – NPI number, Medicaid or Medicare numbers • Credentialing of Staff (examples of licensure verifications) D
  - Documentation – charting of services
  - Coding – list of services and established fees you provide
  - Verification of Client Eligibility – knowing what the client is eligible for prior to providing service
  - Electronic Payment Management System – billing system able to receive electronic checks from providers.

Reasons for Returned Documents

- No signature
- Incorrect version
- Copied agreement
- Stamped signature
- Signature not dated
- Failed to submit required forms
- Completed in pencil

Contracting Policies

- Local health departments should have the following policies written and educate staff on:
  - List name of designated individual who will do the contracting, authorized signer, and that person's back up.
  - Confidentiality statement for person who is doing the contracting. (Have person sign it for compliance with HIPAA).
  - List of HIV services provided by local health department clinic.
  - List of contracted payers and provisions for HIV services.
  - List of community based organizations and contact information.
  - Contracting tracking workbook.

HIV Coding Environment…Now.

HIV Coding Environment….

- Local health departments must use codes sets when submitting claims for reimbursement. (HIPAA requirement)
- All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code and applicable CPT procedure code in order to be reimbursed.

HIV Coding Environment….

- A local health department could provide a service that is covered and described by a CPT® code, but not have the allowable (proper) diagnosis code that justifies reimbursement by the payer.
  - In which case, the claim is rejected and the service will not be reimbursed.
- Individual insurance companies and state Medicaid programs are free to develop a set of reimbursement and payment guidelines, and are not required to cover all services described by a CPT® code.

Documentation and Coding for HIV Services

The Health Record

- Centers for Medicare and Medicaid Services (CMS), health record documentation requirements include:
  - Pertinent facts
  - Findings
  - Observations about an individual's health history including:
    - Past and present illnesses
    - Examinations/tests
    - Treatment
    - Outcomes
- Document every step you take.

Documentation…

- When – document on the day service provided.
- What – document the services provided to the patient.
- Where – Medical Record (SOAP Format, Standard Form, Progress Notes, Problem List, Medication Page, etc.).
- How – Hard (blue or black ink) or EMR. Provider name and credentials MUST be noted!
- Who – All staff who provided a service.
- Why – patient safety, agency safety, provider safety, for billing purposes, research and for quality improvement purposes.
- Authority - Laws requiring medical records and documentation of clinical services.

HIV Testing Documentation

- First visit may include:
  - The signed HIV consent form (varies by state/jurisdiction)
  - HIV test results
  - Notation that the test results were communicated to the patient
- Second visit may include:
  - Written justification for the rationale for the second or subsequent HIV test visit (i.e. risks identified during the first visit requiring further counseling)

HIV Pre-Test Counseling Without Testing Documentation

- Written documentation should clearly state counseling was provided
- The reason why the patient declined testing
- The follow up care plan, including indications for further counseling and testing

Billable Service Types Could Be…

- Evaluation and Management Services
- Risk assessment counseling
- Information / pamphlets
- HIV counseling and testing
- Linkage to Care & Patient Navigation/ Care Coordination/ Case Management
- Screening and treatment for:
  - HIV/AIDS

Non-billable Service Types

- Case management codes are not recognized by Medicare but other insurers may cover them, so it is important to check with the individual insurers.
  - Ryan White Funded Support Service

HIV Billing Codes

- CPT
  - E/M
  - Procedure
- Modifiers
- ICD-10-CM (effective October 1, 2015)
- HCPCS

HIV Testing Codes Example

HIV Testing Codes

ICD-10 Code

Code	Description
B20	Human immunodeficiency virus [HIV] disease

CPT codes

HIV Testing and Counseling Visit		
	Minimal	99401
	Expanded	99402
	Detailed	99403
	Comprehensive	99404
Laboratory		
	HV 1 & 2 rapid test	86703-92

Key ICD-10 Coding Steps

- Step 1: Find the condition in the alphabetic index.
- Step 2: Verify the code and identify the highest specificity.
- Step 3: Review the chapter-specific coding guidelines.

ICD-10-CM Guidelines

- Located specifically in section I.C.1 under Chapter 1, Certain Infectious and Parasitic Diseases (I.C.1.a.1 – I.C.1.a.2.h).
- Code only confirmed cases of HIV infection/illness (I.C.1.a.1).
  - Confirmation does not require documentation of positive serology or culture for HIV, but that the provider's diagnostic statement that the patient is HIV positive or has an HIV-related condition.
- If client is HIV positive and asymptomatic, do not code from Chapter 1.

ICD-10-CM Codes for HIV

- The codes assigned for HIV may include:
  - B20 Human immunodeficiency virus (HIV) disease
  - Z21 Asymptomatic human immunodeficiency virus (HIV) infection status
  - Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus (HIV)
  - Z71.7 Human immunodeficiency virus (HIV) counseling
  - Z11.4 Encounter for screening for human immunodeficiency virus (HIV)
  - R75 Inconclusive laboratory evidence of human immunodeficiency virus (HIV)

ICD-10-CM Code B20…

- B20 is a specific ICD-10-CM code that can be used to specify the diagnosis:
  - **Human immunodeficiency virus [HIV] disease**
- Reimbursement claims with a date of service on or after October 1, 2015 require the use of ICD-10-CM codes.
- This is the American ICD-10-CM version of B20. Other international ICD-10 versions may differ.

ICD-10-CM Code B20…

- Grouped within Diagnostic Related Group(s) (MS-DRG v32.0):
- 969 HIV with extensive o.r. procedure with mcc
- 970 HIV with extensive o.r. procedure without mcc
- 974 HIV with major related condition with mcc
- 975 HIV with major related condition with cc
- 976 HIV with major related condition without cc/mcc
- 977 HIV with or without other related condition

HIV Coding Scenarios

ICD-10-CM HIV Coding Example

- An HIV patient presented to the clinic with what he thought was bruising. A biopsy was performed and a diagnosis of Kaposi's sarcoma of the skin is confirmed.
  - B20 Human immunodeficiency virus (HIV) disease
  - C46.0 Kaposi's sarcoma of skin
  - There is an instructional note under category C46, Kaposi's sarcoma, which reinforces the guideline by stating to code first any human immunodeficiency virus (HIV) disease (B20).

ICD-10-CM HIV Coding Example

- If a patient is being seen to determine his/her HIV status:
  - Z11.4, Encounter for screening for human immunodeficiency virus [HIV].
  - Use additional codes for any associated high risk behavior.
- If a patient with signs or symptoms is being seen for HIV testing:
  - Code the signs and symptoms.
  - An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, if applicable.

ICD-10-CM HIV Coding Example

- What happens if a patient has been tested for HIV and is coming in for test results and they are negative?
  - When a patient returns to be informed of his/her test results and the test result is negative:
    - Z71.7, Human immunodeficiency virus (HIV) counseling

ICD-10-CM HIV Coding Tips

- Do not use the code for HIV (B20) or HIV+ (Z21) when the record/chart states:
  - Suspected
  - Suspicion of
  - Possible
  - Likely
  - Rule out
  - Questionable
  - Consistent with
  - Presumed to be
  - Appears

ICD-10-CM HIV Coding Tips

- Codes designated as principal diagnosis codes are always sequenced first.
- Codes designated as secondary/subsequent diagnoses codes are never sequenced first.
- Opportunistic infection codes are always assigned as the secondary diagnoses if supported by medical record documentation.

CPT Codes for HIV Services

- 99201–99205 for “new” patients
- 99211–99215 for “established” patients.
- Patient services performed by a staff member “incident” to a licensed clinician and supervised by the clinician:

99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Nurse Visits

- 99211 may be billed for certain services provided by a Nurse.
- Not all payers recognize this service.
- Patient must be established.
- Provider-patient encounter must be face-to-face.
- An E/M service must be provided.
  - Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs.

Nurse Visits

- Since 99211 is an E/M code, there are some minimal documentation requirements in order to meet medical necessity for use of the code
  - There must be a face to face encounter
  - Nature of the presenting problem with a diagnosis from prior visit with a clinician
  - Brief history of the problem
  - Documentation of vital signs (sole reason for visit should not be Blood Pressure check or Blood Draw)
  - Plan of care
  - Date/signature of the nurse or other provider

Services Not Billed Under 99211

- Administering routine medications by physician or staff whether or not an injection or infusion code is submitted separately on the claim
- Checking blood pressure when the information obtained does not lead to management of a condition or illness
- Drawing blood for laboratory analysis or for a complete blood count panel, or when performing other diagnostic tests whether or not a claim for the venipuncture or other diagnostic study test is submitted separately
- Faxing medical records

Services Not Billed Under 99211

- Making telephone calls to patients to report lab results and reschedule patient procedures
- Performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed, or payment is bundled with reimbursement for another service) whether or not the procedure code is submitted on the claim separately
- Recording lab results in medical records
- Reporting vaccines
- Writing prescriptions (new or refill) when no other evaluation and management is needed or performed

Preventive CPT Codes

- Preventive medicine codes used in the absence of an established diagnosis.
  - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
    - 99401 approximately 15 minutes
    - 99402 approximately 30 minutes
    - 99403 approximately 45 minutes
    - 99404 approximately 60 minutes

HIV Screening CPT Codes

- Antibody
  - 86701 HIV-1
  - 86702 HIV-2
  - 86703 HIV-1 and HIV-2, single result
    - (For HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result, use 87389)
    - (When HIV immunoassay [HIV testing 86701-86703 or 87389] is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual code)

For Medicare Patients Use… HCPCS Codes

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 asssay (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

HIV Screening CPT Modifiers

- Modifier 33
  - Informs the payer that the service is a service recommended by the USPSTF.
- Modifier 92, Alternative Laboratory Platform Testing
  - When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389).

Modifier QW– CLIA Waived Test

- Laboratory provider must have:
  - Certificate of Compliance
  - Certificate of Accreditation or Certificate of Registration in order to perform clinical diagnostic laboratory procedures of high or moderate complexity.
- Waived tests include test systems cleared by the FDA designated as simple; have a low risk for error ;and are approved for waiver under the CLIA criteria.
  - Only report with Path/Lab test codes (86701-86703, G0433G0435)
  - Do NOT report on any other code type
  - If a combination of waived and non-waived tests are performed, modifier QW should not be used
  - Contact your local Medicaid agency for specific guidance

Codes for Laboratory Services

- Bill laboratory codes for laboratory tests done on site.
  - CPT Code 36415 = one venipuncture collection fee when the lab work is sent out to an outside lab regardless of the number of specimens drawn.
    - HIV Blood Draw
  - CPT Code 99000 = handling, transfer and/or conveyance of specimen from LHD to another laboratory.

Maintenance of HIV Coding Processes

Coding Maintenance

- Local health departments/clinics could improve their coding processes by:
  - Updating code sets based on given regulatory schedule
  - Reviewing local coverage determinations (LCD) and national coverage determinations (NCD) by payer
  - Collaborating with physicians and other clinicians on documentation accuracy
  - Working with vendors
  - Working with payers to review contractual coding changes or updates
  - Analyzing revenue risks
  - Performing claim reviews
  - Conducting coding compliance audits

HIV Screening Denials

- A screening test may be denied because:
  - The test was done in a setting in which a bundled payment was negotiated for the service, and the screening is not included in the negotiated rate.
  - The patient is already diagnosed with the condition, and no longer needs to be screened for the illness.
  - An incorrect diagnosis is reported.
  - The payer has established frequency limits for the service.
  - Modifier 33 was not appended to the CPT® or HCPCS code.

Understand the HIV billing environment…Now.

2016 Survey

- NASTAD HIV TESTING & BILLING REPORT 2016
  - In 2015, collected data from 52 state, local, and territorial health departments.
  - Topics related to health department:
    - Supported HIV testing including: test volume, testing technologies, testing settings, integration of hepatitis C (HCV) testing with HIV testing, and third-party billing practices.

NASTAD Survey 2016

Table 12: Payers for Health Department-Supported Testing Services Delivered by Subcontracted Providers (N=44)		
	N	**Percent**
Medicaid	27	52%
Private Insurers	23	44%
Medicare	15	29%
Don't Know	12	23%
Other	5	10%

Source: https://www.nastad.org/sites/default/files/NASTAD_Testing_Billing_report_FINAL.PDF

NASTAD Survey 2016

Table 13: Challenges to Implementation of Third-Party Billing for HIV Testing (N=52)			
	Number Ranking	Median Rank	Overall Rank
HIV/AIDS Program Staff Lack Knowledge of Billing/ Reimbursement	32	2.0	1
HIV/AIDS Program Lacks Capacity to Support Implementation	31	2.5	2
Community-Based Providers Lack Capacity to Bill	28	3.0	3
Confidentiality of Explanation of Benefits	26	3.5	4
Challenges in Contracting with Insurers	25	3.0	5
Other Service Providers Lack Capacity to Bill	21	3.0	–
Health Department Lacks IT Capacity to Implement	21	3.0	–
Other	20	2.0	–
Majority of Patients Uninsured	20	2.5	–
Difficulty in Becoming Qualified Provider	19	5.0	–
Community-Based Providers Do Not Use Electronic Medical Records	18	3.0	–
Health Department Does Not Use Electronic Medical Records	14	3.0	–
Don't Know	12	2.0	–
Providers Lack Capacity to Collect Unpaid Bills	12	4.0	–
Global Payments	11	3.0	–
Poor Reimbursement Rates	11	4.0	–
HIPAA Privacy Concerns	10	4.0	–
Services Not Covered by Insurance	7	3.5	–
Other Service Providers Do Not Use Electronic Medical Records	6	5.0	–

Source: https://www.nastad.org/sites/default/files/NASTAD_Testing_Billing_report_FINAL.PDF

Identifiers Needed for HIV Billing

- Taxonomy code
- Tax Payer identification number
- Provider National Identifier number (NPI)

Understand key steps and documentation needed for HIV billing.

HIV Billing Revenue Cycle

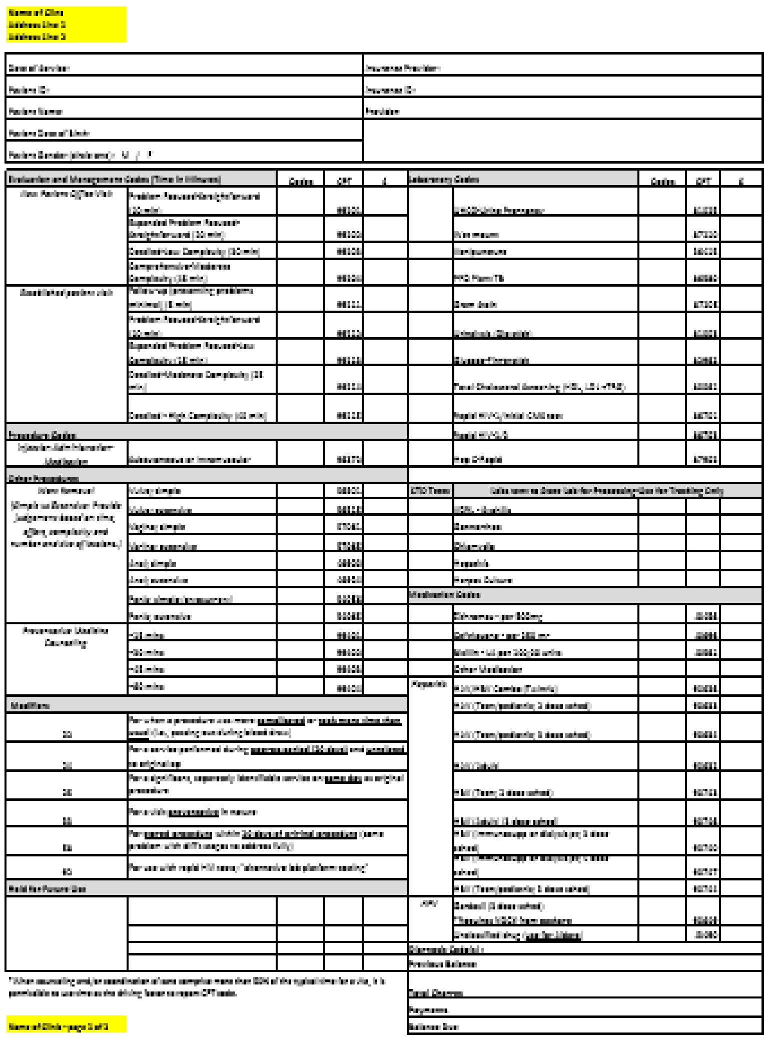
Elements of the Revenue Cycle	
Pre-Visit	• Collect client information • Verify coverage • Determine client pay amounts • Communicate payment policies prior to service provision
Visit	• For walk-ins collect client information and verify coverage • Collect client pay amounts (co-pay or co-insurance) • Document and code services provided
Post-Visit	• Bill, collect and track payment for services

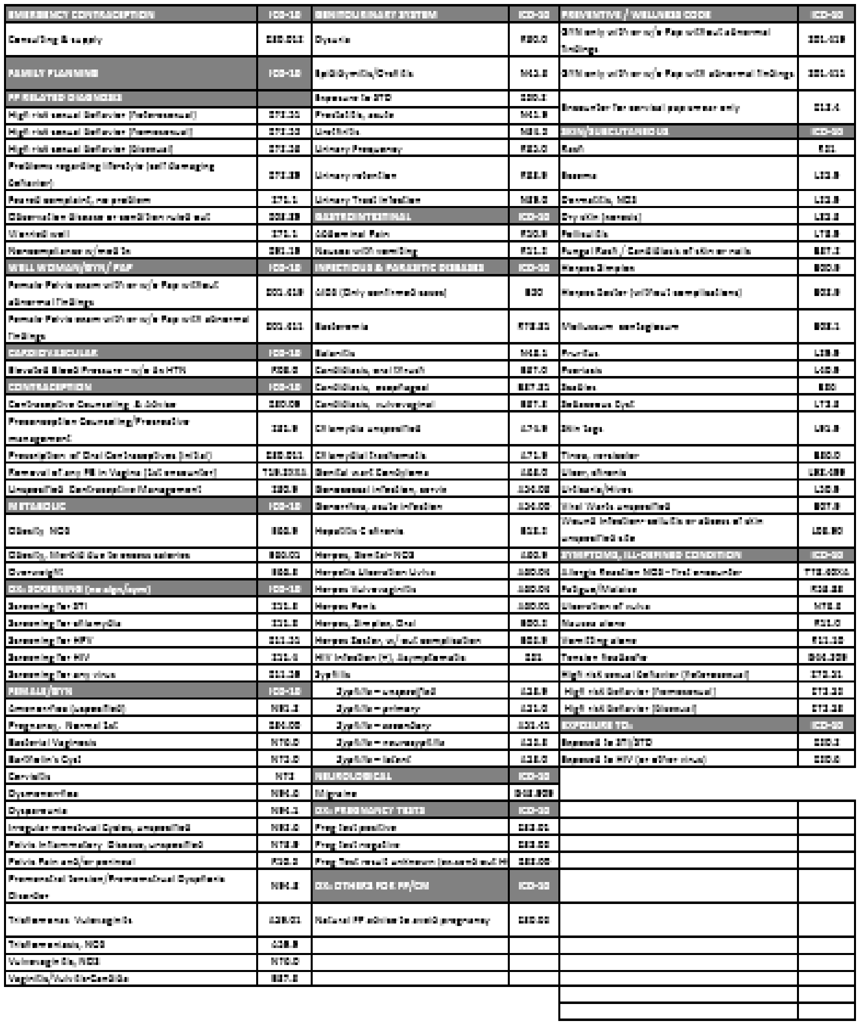
Billing Cycle

Superbills, Charge Tickets, and Encounter Forms

- Communication tool between clinician and biller describing what occurred during the encounter
- Electronic or paper – includes Diagnosis, CPT, modifiers
- Be careful with EHR templates and pre-assigned codes
- Is it up-to-date and reflective of all services provided?
- Can clinicians sequence and note co-equal diagnosis codes?
- Can modifiers be noted?
- Reminder - Only the person providing the services should complete the superbill

Superbills, Charge Tickets, and Encounter Forms





Collect Billing Information

- Different sources
  - Providers
  - Clients
  - Insurers
  - Medicaid/Medicare
- From Clients/Insurers
  - Member number/Group number
  - Plan address
  - Beneficiary/Subscriber number
  - Client's social security number (may be optional)
- From Providers
  - Procedure and diagnosis information (CPT and ICD codes)

Fee Structures

- Fee schedules
- Fees and private insurance
- Standard fees for payers
  - Medicare
  - Medicaid
  - Private insurance
  - Self pay
- Payment policies
  - Sliding scale
  - Time of service/Cash discount

Billing Methods

- Billing Vendor
  - Outsourced billing services
- Billing Staff
  - Clinic staff bills to payer
  - Clearinghouse used by Clinic staff to bill

HIV Billing

- FFS Medicaid covers 5 types of HIV visits, 3 have to do with testing (certain visits can be billed same day).
- Managed Care Organizations and commercial (private) plans have an entirely separate set of codes to use but similarly, will allow for same day billing of these visits.

Billing Requirements and Processes

- Distinguish between public health and private health policies and become familiar with minimum billing requirements.
- Assess your technical billing capabilities to identify the billing process that best fits your needs (i.e. use of paper claims versus electronic claims transactions; in house billing versus outsourcing to a clearinghouse or medical billing company).
- Learn what insurers want. There are a variety of ways to bill and products that span from large billing and provider-management systems to simple word processing and email.
- Ensure information is exchanged in a secure fashion.

Billing Requirements and Processes

- Identifying the services you provide and the ones you want to bill for.
- Understand what processes you already have in place.
  - You may already bill Medicaid, Medicare and your clients so you might not need to make that many changes.
- Identifying processes, policies and resources you'll need to begin billing.
  - Once you know what your processes are, you can identify what changes are needed to begin billing.
  - Changes to your processes are usually led or followed by changes to policies and resources.

Review Contract Terms

- Review terms for:
  - Balance Billing - occurs when the LHD bills the client for the difference between what they charge and the health insurance allowable amount.
    - Some contracts between insurers and LHDs do not allow providers to balance bill. A provider who "Accepts Assignment" agrees not to balance bill patients.

Review Contract Terms (continued)

- Review terms for:
  - Fee-for-Service insurance - seldom pays 100% of what providers charge.
    - The "Allowable Amount" is the price that an insurance company will pay for a specific service.
      - This amount is based on a negotiated "Fee Schedule."
      - Sometimes it is based on the "Usual and Customary Charge" for providers in a given geographic area.

Billing Codes

- CPT
  - E/M
  - Procedure
- Modifiers
- ICD-10 Diagnosis
- HCPCS

Bill Submission

Paper CMS 1500

- Mail
- Fax
- Email

Electronic File Transfer (EFT)

- File saved to computer
- File is uploaded by other program(s)

Direct Data Entry (DDE)

- Data entered on insurance website
- Logon to web based system

Remittance Methods

- Paper
  - Mail
  - Email (payment may come separately from remittance)
- Electronic
  - Sent directly to bank account through EFT
  - Clearinghouse
  - Payer makes on-line viewing and downloading of payment and/or remittance
- Auto-remit
  - Mail
  - EFT

Inform HIV Billing Team…

- AIDS/HIV Services provided by local health department/clinic
  - Screening/Evaluation
  - Testing/labs
  - Diagnosis
  - Counseling
  - Treatment/Medications
- HIV related terms
- HIV care continuum
- Clinical staffing model
- Visit frequency and duration

Inform HIV Billing Team…

- Formulary adequacy
- Preventive, clinical, care management, and other services offered
- Adequacy of payment models

Most Common Denials…

- Patient not eligible
- No authorization
- Not medically necessary
- Incorrect codes
- Duplicate claim
- Non-covered
- General technical billing errors i.e. Incorrect subscriber ID, missing info on UB format, etc…
- Timely filing
- Additional data is required

Summary

- Credentialing can be tedious but follow through is important.
- Attempt to get all communication from a payer in WRITING!
- Email is your best friend!
- Use certified mail whenever possible! Do not be complacent!
- Make no assumptions your application is received, in process, or approved.
- You must follow-up regularly!

Summary

- If your health department has access to an attorney, it is highly recommended to have contracts reviewed by legal counsel.
- Familiarize yourself with contracting terms.
- Health plans like data.
- Be familiar with contract language and know where your health department can negotiate:
  - Types of Services Provided
  - Schedule for Reimbursement Rates
  - Auto-renewal
- Confidentiality can be addressed during the contracting process.
  - Suppression of the explanation of benefits for confidential services like HIV testing, services, and treatment.

Summary

- Proper HIV documentation and coding could support compliant HIV billing practices.
- Make HIV coding more efficient.
  - Develop a list of your most commonly used ICD-10 codes, CPT codes, G codes, and modifiers by payer.
  - Invest in an inexpensive software program that helps with coding. (if applicable)
  - Review ways to make sure new coding processes do not delay payments.
    - Look at your most common non-visit services—do any of them trigger reviews or denials related to medical necessity?
- It is important to understand how to code these services correctly under ICD-10.
- Update your superbill/billing form to the most common codes and updated code sets. (eg. ICD-9 V codes to ICD-10 Z codes)

Additional Resources

Additional resources (including linkage to care):

American Academy of HIV Medicine
Referral Link
www.aahivm.org

American Medical Association
CPT home page
www.ama-assn.org/go/cpt

HIV Medicine Association
HIV Provider Listing
www.hivma.org

National Clinician's Consultation Center
Compendium of state laws regarding HIV testing
http://www.ucsf.edu/hivcntr/stateLaws/index.html

Centers for Disease Control and Prevention
CDC's National Prevention Information Network
(800) 458-5231
www.cdcnpin.org

CDC revised recommendations on routine testing for HIV
www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

Centers for Medicare and Medicaid Services
Medicare Coverage Center
www.cms.gov/center/coverage.asp

For more information contact:

American Medical Association
515 N. State St.
Chicago, IL 60654
(312) 464-4147

American Academy of HIV Medicine
1705 DeSales Street NW
Suite 700
Washington, DC 20036
(202) 659-0699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