Iowa Department of Public Health

Behavioral Health

Bureau of HIV, STD, and Hepatitis

HIV/STD/HCV Services

Revenue Generation

For

Iowa Local Public Health Agencies

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Section 1: Introduction

There has been a significant shift in public health operations and funding over the last decade. In recent years, costs have escalated, demand for services has increased, and some traditional funding sources are threatened.

Currently, there are eight Local Public Health Agencies (LPHA) in Iowa that receive assistance for the detection and treatment of Human Immunodeficiency Virus, Sexually Transmitted Diseases, and the Hepatitis C Virus (HIV/STD/HCV) services. The purpose of this guide is to inform these LPHA how to analyze existing systems, resources, and other factors involved in developing a successful structure for the generation of increased revenue. The contents are intended to help LPHA determine if they charge patients for HIV/STD/HCV services and/or establish the infrastructure to bill government and private insurance plans.

The manual's contents are being drawn and organized from a wide range of resources. Interviews were conducted with Iowa's LPHA that currently are billing for HIV/STD/HCV services or they are in the process of establishing a program for billing. Some information comes from a billing manual created for the Iowa Department of Public Health Bureau of Immunization & Tuberculosis in 2012. All of this data has been updated to describe the billing environment today and to focus on HIV/STD/HCV services. Additional information has been gathered from other national sources that have addressed the topic of revenue generation as related to HIV/STD/HCV services. The information provided is as comprehensive as possible while realizing that each individual LPHA may encounter unique situations in the billing process.

The ultimate goal of this project is to provide Iowa's LPHA with the information and tools they need to receive payment for their services, if and when they decide it is feasible.

1.1 Public Health Environment

Over the past five years, charging patients for services and implementation of third-party (insurance) billing have been much-

discussed topics for LPHA across the country. In Iowa, many LPHA have begun charging for services for the first time. They have also implemented the process of billing Medicare, Medicaid, and private insurance plans for immunizations and other related services. They've purchased computerized Electronic Health Records (EHR) programs that include Practice Management solutions for the electronic submission of claims to third-party payers.

1.2 Affordable Care Act

The Affordable Care Act (ACA) that was passed in 2010 is also forcing changes in the decision-making process of LPHA. First, it guarantees coverage for those persons with pre-existing conditions such as HIV. Plus, in many areas of the country, the uninsured population has decreased by as much as half, with that number expected to increase over time.

In Iowa, during the 2016 open enrollment period, 55,089 people enrolled in private insurance plans through the Iowa Health Insurance Exchange/Marketplace. Kaiser Family Foundation data indicates there were still 188,000 uninsured residents in Iowa in 2015, however, 47% of them were eligible for the state's expanded Medicaid coverage. Another 16 percent were eligible for subsidies to help purchase private health insurance coverage, as long as they buy a plan through the Iowa Marketplace/Exchange.

As more individuals are insured, there is increased likelihood that they will take advantage of the health system, thus expanding opportunities and challenges for community-based care and treatment. This includes Iowa's LPHA that offer HIV/STD/HCV services.

It is anticipated that the unprecedented number of people with insurance coverage and the resultant move toward a primary care network for HIV/STD/HCV services will continue to erode traditional grant funding. Ultimately, if LPHA are not prepared to request payment from patients and/or submit claims to private and government insurance plans, the traditional role and responsibility of the LPHA to deliver these preventive services is likely to change significantly. These payment-related decisions will have a bearing on how to stay involved and relevant in today's ever transitioning health care environment.

1.3 Generation of "New Money"

Revenue Generation is an action term. It references an action that begins with the revenue an LPHA may already have and rely upon. Then, through the successful implementation of certain systems and programs, there is a resultant increase of the overall revenue stream.

Generation of new revenue, "new money," gives the LPHA the ability to help offset a budget shortfall, to increase staffing, to extend services to a broader spectrum of patients, to offer additional services, or whatever purpose the LPHA deems appropriate.

1.4 Revenue Generation Opportunities

There are two fundamental methods of generating patient-related revenue from the delivery of HIV/STD/HCV services.

- **Patient Pay**
  The most obvious option for revenue generation is to ask patients receiving HIV/STD/HCV services to be responsible for some or all of the cost. This is often referred to as "first-party payment" or "patient-pay responsibility." Setting fees for services, asking for payment, and providing sliding fee schedules for the underinsured or for hardship cases are all a part of this revenue generation opportunity.

- **Insurance Billing**
  Receiving reimbursement for HIV/STD/HCV services by billing government and private insurance plans, referred to as third-party payers, is readily achievable. In addition to Medicare and Medicaid, patients can obtain insurance coverage from private insurance plans as well as those offered in the Marketplace as a result of the Affordable Care Act.

    - **Billing Iowa Medicaid**
      Billing government programs such as Iowa Medicaid and its affiliated Managed Care Plans (MCOs) offers a second opportunity to create new revenue streams. Iowa Medicaid will allow payment to LPHA for a wide-ranging list of services. The list of services covered by Iowa Medicaid was expanded as a result of this project.

- **Billing Medicare**
  Medicare Part B covers HIV screenings and sexually transmitted disease (STD) screenings for Chlamydia, Gonorrhea, Syphilis, and/or Hepatitis B once every 12 months or at certain times during pregnancy.

  Those patients with Medicare Part B who are at increased risk for STDs can also receive up to two individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year. To be payable, these sessions must be ordered by a primary doctor or other primary care practitioner. Currently, Medicare will only pay for behavioral health counseling sessions if a primary care practitioner provides the service and the service takes place in the primary care doctor's office or a primary care clinic.

- **Billing Private Insurance**
  Billing third-party insurance such as Wellmark Blue Cross Blue Shield or United Healthcare can be the LPHA's most lucrative source for "new money." Their reimbursement rates greatly exceed the amounts paid by either Medicare or Iowa Medicaid. Conversely, the billing process can be time consuming and very challenging.

- **Controlling Costs as a Revenue Generation Strategy**
  Any discussion of revenue generation cannot be complete without considering the topic of cost controls as a method of possibly creating additional indirect revenue. Consider that any reduction in costs creates an equal increase in usable revenue against a predetermined funding stream.

  Regardless of how an LPHA categorizes its costs, each category must be measured and evaluated. Is the cost in line with the necessary and expected productivity?

- **The Bottom Line**
  The bottom line is that there are more patients today than ever before with a means of payment and they are seeking confidential services from their LPHA. With this in mind, the LPHA will want to study and analyze all of the data presented here so it can make a constructive decision as to if or how it wishes to proceed toward maximizing its revenue generating potential.

1.5 Revenue Generation Challenges

Iowa's LPHA that provide HIV/STD/HCV services face some very specific challenges when considering implementation of programs aimed at generating new sources of revenue. Here are just a few:

- **Philosophical Questions**
  Historically there has been and continues to be concerns that charging for HIV/STD/HCV services might dissuade underinsured patients from seeking services. Advocates of receiving payment for these services contend that there are ways to avoid this drop off. Implementation of sliding fee schedules governed by hardship policies is just one possible solution. Excellent communication with patients about their options will also aid in this area.

- **Misunderstood By Payers**
  Many of Iowa's LPHA already have experience generating revenue outside of grant programs. They have learned that forging relationships with private insurers can be challenging as these payers are not always familiar with the services and operations of LPHA. For example, the concept of providing services under the standing orders from a Medical Director is foreign to many insurance companies. The company guidelines and policies that they must follow generally do not include information on standing orders.

  The thought of an insured patient being treated at an LPHA rather than by a preferred provider in the patient's "medical home" is not always embraced by third-party payers. Some do not recognize the patient's desire to seek confidential services that may exclude the traditional "family doctor" scenario. All of this can lead to challenges when the LPHA tries to enroll as a preferred provider with an insurance plan. Furthermore, if enrolled, it may hinder the ability to be paid for some services.

  The good news is that LPHA across the country have been paving the way on these issues over the last four to five years as they've been working to enroll with third-party payers to receive payments for a wide range of services.

- **Limited Scope of Payable Services**
  When it comes to receiving payment for services delivered under standing orders, some insurance plans will limit the

scope of services that are payable to Local Public Health Agencies. For example, Iowa's largest private insurance provider, Wellmark Blue Cross Blue Shield offers a narrow list of services payable to LPHA. Primarily, it focuses on immunizations. Wellmark Blue Cross Blue Shield has simply stated that they prefer that their subscribers seek treatment with their family physician, also referred to as their medical home.

If the LPHA has an Advanced Registered Nurse Practitioner (ARNP) or a physician (MD, DO) that is enrolled as an individual provider, they are then able to bill and be paid for a much larger list of services than if billing under a public health group contract and standing orders.

- **Check-in Requirements**
  For most medical billing operations, the front desk/receptionist position is vital to the success of any revenue generation program. If solely conducting a patient-pay program, this employee must be highly skilled at dealing with patients and requesting payment.

  When managing a third-party billing operation, the front desk/receptionist or another LPHA employee will also have to be skilled in the collection of co-payments or co-insurance as prescribed by the insurance companies. It's important to consider that many of today's co-payments can be $60 to $80 dollars. If not collected at the time of service, this is probably lost money. Also, many ACA plans have deductibles ranging from a few thousand dollars to even $8,000, or more. For patients with these large deductible amounts, expenses incurred for medical services will likely be the patient's responsibility for payment in full. On the other hand, some patients come to the LPHA because they need a hardship waiver of these out-of-pocket expenses. The LPHA front desk/receptionist must be trained to deal with this wide range of circumstances.

- **Infrastructure**
  Unless already billing for other services, most LPHA do not have the staffing or computer systems in place to create and implement a complex insurance billing system. For most, creating the mechanisms for a patient-pay program will be very manageable. Implementation of a third-party billing program will usually require the addition of specialized staff that understands medical coding, claim filing, etc. A robust computer system with specialized

Electronic Health Records and Practice Management System software will be required. Billing Sections 7.4, 7.5, and 7.6 of this manual include details on these topics.

- **Confidentiality**
  Implementation of a patient-pay program should not create any new concerns about confidentiality of patient information. Patient payments should be received at the time and place of service. Mailings or other communications do not need to be generated as a result of these payments.

  Billing government and private insurance plans requires the sharing of information about potentially sensitive services with people and organizations outside the LPHA. Submitting a medical claim to an insurer will typically result in the generation of an Explanation of Benefits (EOB) that is mailed to the insured party. The EOB will specify what services were received, who received them, and when the services were delivered. If others, such as family members, are able to see the EOB, the patient may view this as a breach of his or her confidentiality.

  The National Association of County and City Health Officials recommends that LPHA protect confidentiality by asking patients prior to receiving HIV/STD/HCV services if they will approve that the LPHA bill their private insurance. This ensures that patients are aware of their privacy rights and that EOBs are sent by insurance plans.

  Iowa Medicaid has undergone a transition from being managed by state government to being privatized. While a small percentage of claims will still be processed by the original Medicaid, most will be paid through three privately owned Managed Care Organizations (MCO)/insurance companies. When billing traditional Medicaid or any of the three MCO, privacy and security of information should not be a concern. They currently have policies to suppress EOB reporting of specific HCPCS/CPT Codes, Diagnosis Codes, and Pharmacy Classes related to HIV/STD/HCV services.

  Prior to billing any of the Iowa Medicaid payers, it is suggested that LPHA contact each of them to ensure that their policies have not been altered and still include EOB suppression for HIV/STD/HCV services. Even with the promise of EOB suppression, it is also a good idea to make

certain that patients understand that their Medicaid plan will be billed for the services.

- **Adequate Revenue to Justify Billing Programs**
  The goal of charging for HIV/STD/HCV services and/or billing third-party payers is to help diversify revenue streams and bolster budgets. Therefore, it is important to analyze potential expenses as related to revenue possibilities. For example, some LPHA may not have adequate HIV/STD/HCV service volume to justify the expense of additional staff, computer systems, and other overhead related to insurance billing. The net result would be a less than profitable experience. Therefore, accurate projection of both revenues and expenses is vital. Estimating expenses may be the most challenging.

  Broad categories of fixed and variable costs should include such items as facilities, utilities, administrative technology, phones, FAX, copy machines, computers, scanners, software, office supplies, and costs of administrative staffing. Add to this medical technology, computers, electronic health records (EHR) and billing software, medical test-related equipment, medical supplies, and medical staffing.

  Estimates related to staffing may be the most challenging. Staffing issues are complicated by several variables. They include, but are not limited to the total number of staff members, job descriptions, workload, efficiency, compensation, benefits, coverage for personal time off, and more.

  Regardless of how the LPHA categorizes its costs, each category must be measured and evaluated. Is the cost in line with the necessary and expected revenue? If any issues are discovered, they must be addressed.

- **Outsourcing Insurance Billing**
  In some cases, outsourcing of third-party billing may be a more viable option than performing all functions internally. Generally, outsourcing requires less LPHA staff involvement and it eliminates the need to purchase specialized computer software systems. A more detailed look at outsourcing is included in Section 8 of this manual.

Section 2: Patient-Pay Program/No Insurance Billing

When an LPHA implements the patient pay option, it is asking patients to take responsibility for all or an appropriate part of the charges for HIV/STD/HCV services. Payment options may include cash, check, credit or debit card, health savings account, or any combination of these. Regardless of whether or not a patient has active insurance coverage, all individuals would be treated the same.

2.1 Prior Notification of Payment Requirements

The first contact with a patient seeking HIV/STD/HCV services is most often when he or she arrives at the clinic's reception desk. However, there are instances when a patient may call the clinic in advance to gain information and, if appropriate, set an appointment.

If an LPHA typically asks for payment for HIV/STD/HCV services, it may be appropriate, whenever possible, to notify the patient in advance of arriving at the clinic. The potential risk of doing this is that it may discourage some patients from honoring their appointment or coming in during pre-set clinic hours. Some LPHA choose to wait until the patient is registering at the front desk to discuss payment options. A face-to-face discussion may provide a better opportunity to inform the patient what is required and to assure those that cannot pay in full, that they will still receive services.

2.2 Registration Desk/Initial Encounter

After greeting the patient and determining the reason for the visit, there is always a certain amount of paperwork that must be completed. In addition, this may be the best time to inform patients that there may be a charge for services, and determining the patient's ability and willingness to pay. Essential to this discussion is to reassure the patient that if he or she cannot pay, special arrangements can be made. (See Patient Advocate in Section 2.4 for alternate financial counseling procedure.)

The following language is effective for this purpose without being aggressive or shutting out the possibility of other arrangements being made.

> *"There may be a charge for your services today."*
>
> *"We accept cash, checks, credit or debit cards, and health savings accounts…or do you need to (would you like to) make other arrangements?*

An LPHA can also add the following if deemed appropriate. However, using this statement may have an adverse effect on patients paying some or all of their charges.

> *"Please be assured that even if you can't pay anything for your services, we will still see you."*

If the patient is paying for services, the payment is often taken prior to treatment. However, a common problem is the ability to determine in advance what the actual costs will be.

2.3 Hardship Policy

When implementing a third-party billing program, one of the early steps in the process is for the LPHA to establish a fee schedule that is based upon the amounts paid by the most common insurance companies. This will be explained in detail, later in this manual. These fees are generally higher than most LPHA would normally charge for services. But, what can safety-net providers do about patients who cannot afford these elevated fees?

The best and most common way to address this is to create a Hardship Policy that includes a sliding fee schedule. The levels within this fee schedule are up to the individual LPHA. However, to be valid, the fee schedule must be in writing, be part of a uniform policy and it must not be discriminatory. In other words, it must be applied equally and fairly to all patients.

There are some standard steps that are common when generating an LPHA Hardship Policy. They include:

1. LPHA commonly establish a discount by basing it on incremental percentages from the Federal Poverty Level (FPL). Sliding fee schedules apply to patients falling between 101% - 200% of FPL. LPHA also usually establish pay classes by household size. Pay classes are increments

of 10%, 25%, or a percentage the LPHA feels is best for its clinic. For patients falling below 100% FPL, the LPHA may continue to be their safety-net provider by not charging any fees for their service or by charging a nominal fee.

2. To qualify for the Hardship Policy, patients should be required to complete an application. Some LPHA choose to accept the patient's word, while others require some verification such as copies of tax returns or current pay stubs from their place of employment. Other possible validation of a patient's qualification may be receipt documentation of public assistance programs such as Social Security income (disability), temporary assistance of needy families, or a free or reduced cost school lunch program.

   All acceptable forms of documentation should be listed in the Hardship Policy. The application should also note which clinic services are included and excluded, so patients fully understand their financial obligations.

3. The LPHA will need to monitor the financial status of returning patients. Patients should be recertified for the Hardship Program on a minimum of an annual basis. After establishing a Hardship Program, the LPHA should use signage within the facility, and website notification to make patients aware of its availability.

The combination of a Hardship Policy with a sliding fee schedule, implemented with an updated fee schedule, will allow LPHA to continue to be a safety-net provider while also maximizing revenue from private payers.

2.4 Patient Advocate

Some Iowa LPHA have created a Patient Advocate position to undertake discussions related to the purpose for the visit, handling of payments, and implementation of hardship policies. After being greeted in the reception area, the patient will generally meet with this key staff member in a private office or isolated area to help ensure the privacy of discussions.

This process moves the patient away from the reception desk so other patients can be handled in a timely manner. At the same time, it moves sensitive discussions away from a public area and reinforces the belief that the patient is important and the LPHA is very concerned about the patient's needs and privacy. It also

places the patient in the hands of a skilled professional that can be trained to efficiently discuss patient financial information and propose workable payment solutions.

The process requires a skilled staff member to fill the Patient Advocate position. Also, providing private consultation space adds operational costs without any increase in offsetting revenue. If an existing staff member can be re-directed to provide this service without creating a void elsewhere, that may be a viable option.

2.5 Patient Encounter

Each LPHA has developed a workflow for the patient encounter. In regard to payment for HIV/STD/HCV services, there are a couple of important issues. First, it is recommended that a formal superbill be created to record services provided as related to the payment process. Today, more and more LPHA are using Electronic Health Records (EHR) software for charting, or they may maintain a paper chart to document services. The superbill or what is sometimes called the "charge ticket" is usually a check-off form where the provider can indicate all services provided on a particular date of service. This, in turn, can be used to determine and document the amount owed by the patient. The superbill may be a paper form or it might be an electronic form within an EHR program. A thorough discussion of superbills and samples are included in Billings 7.10 and 7.11 of this manual.

2.6 Check-out

The check-out process is probably the best time to finalize and collect payment from the patient. Until this point, the LPHA really cannot determine the exact amount owed. However, some LPHA resist collecting at the end of the process for several reasons. First, due to floor plans in the clinic, it usually requires a staff person to get the patient back to the receptionist or to a check-out clerk to process the payment. It could require two staff members to be successful, and most LPHA do not have adequate resources to support this function. In theory, the receptionist and a Patient Advocate would still be busy with the intake process. Nevertheless, the time after the appointment is concluded provides the best information to determine actual costs/charges for the visit.

2.7 Payment Options/Health Savings Accounts

The more payment options available to patients, the better chance there is of receiving payment. In today's environment, the ability to accept debit and credit cards as well as cash and checks is essential.

Health Savings Accounts (HSA) provide another option. An LPHA does not have to be enrolled with any insurance plans to accept this form of payment. Patients with HSA have paid into an account and are able to draw out of it as a means of payment for healthcare services. These plans provide patients with certain tax advantages. And, with rising deductibles for traditional insurance plans, the HSA concept has grown in popularity. For the LPHA, an HSA is no different than receiving a credit card payment.

The patient will have a special HSA credit card that can be swiped with a standard issue credit card reader. It is important to note that the LPHA's credit card processing company must classify the LPHA as a "health care provider" when service is established with them. The LPHA cannot be listed as county government, etc. Without this health care designation, the payment will not made.

2.8 Setting Fees

How much to charge for HIV/STD/HCV services in a patient-pay program can be a controversial topic. In this environment, the level of fees is likely to depend greatly upon the overall philosophy of the LPHA.

Many LPHA will go to great lengths to determine their actual cost for delivery of a particular service and that will be the fee. LPHA that participate in Title V funding are limited by Title V guidelines to only charge their exact costs for the service. They cannot charge more than that. Other LPHA that do not have these restrictions may base their fees on amounts that are paid by private insurance companies or Medicare. A detailed explanation of setting fees based on insurance company payments for specific codes is included in Section 7.9 of this manual.

2.9 Workflow Decisions

LPHA facilities vary greatly. Staffing availability is a wide-ranging variable. Overall, availability of funds will vary. And, the populations served by each LPHA vary in numbers and needs. As a

result, it is difficult to create a single workflow that meets the needs of everyone. The above concepts provide options that should be considered, customized, and tailored to best utilize resources to meet the goals of each individual LPHA.

Section 3: Introduction to Third-Party Billing

Implementation of a third-party billing program can potentially add significantly to the revenue stream of an active LPHA. As mentioned above, it is very important to fully understand the costs involved in developing a billing system. Equally as important is the time commitment and dedication required to achieve the goal of successfully receiving a steady flow of payments from insurance plans.

3.1 Payer Mix and Patient Participation

One of the first steps recommended to LPHA prior to getting started is to conduct a survey of current patients receiving HIV/STD/HCV services. There are two primary goals. The first is to determine what is referred to as the payer mix among insured patients.

Gather information from all patients over several months to get an accurate sample. Build a list that shows how many of the LPHA's clients are covered by Medicare, Medicaid, Wellmark Blue Cross Blue Shield, Midlands Choice, United Healthcare, Coventry, etc. This sample should generate a list of payers that the LPHA needs to enroll with.

The same list will also be helpful in determining overall revenue potential. For example, most private insurance companies will likely pay as much as double the amount allowed by Medicaid for the exact same service.

The second goal is to determine if HIV/STD/HCV patients with insurance are willing to allow the LPHA to bill their insurance plan if such a program was implemented. This will help with the question of how much revenue can be budgeted as the result of an insurance billing program.

When an LPHA is enrolled with a third-party payer, they will also receive a copy of the current fee schedule for that payer. These fee schedules can be used to establish a fee schedule and to estimate potential revenues, based on patient survey information.

- **Cerro Gordo County Health Department Survey**
  In 2013, the Cerro Gordo County Health Department completed a short survey in which it asked it's HIV/STD/HCV patients if they had health insurance, and if

they did, were the patients OK with having their testing services billed to their insurance.

Of 170 respondents, 48% had some form of health insurance: private, Medicare or Medicaid. Of the 52 respondents who had private insurance, 39% were comfortable submitting to their insurance company. Of the 30 who had Medicare or Medicaid, 86% were comfortable submitting claims.

This type of localized information is invaluable when planning an HIV/STD/HCV billing program.

3.2 Cost Analysis

It makes great sense to do a thorough cost and expense analysis at this time. However, a better understanding of the billing and payment processes will prepare program administrators to do a more accurate job of estimating results. Additional information related to conducting a cost analysis is included in Section 9 of this manual.

Section 4: Introduction to Enrollment

There are two primary operations involved in the act of billing third-party payers for HIV/STD/HCV services:

- **Enrollment** with selected government and commercial healthcare plans, and…
- **The billing process**: the actual process of submitting claims and receiving payments for services rendered to the members of such third-party payers.

Out of necessity, enrollment must precede the billing process. Billing is discussed in Section 7 of this manual.

4.1 Enrollment

Enrollment is the process of receiving permission from a third-party payer so an LPHA as a facility, and/or employed healthcare providers, can receive reimbursements for allowable services. Healthcare providers may be Medical Doctors (MD or DO), Advanced Registered Nurse Practitioners (ARNP), and Physician Assistants (PA).

Enrollment is made up of two basic parts -

- **Credentialing** and
- **Contracting**.

4.2 Credentialing

Credentialing is a process in which detailed information related to a provider or facility is gathered and submitted to a third-party payer for approval. The information generally relates to the applicant's identity, education, professional credentials, and worthiness to be associated with the payer.

If the applicant meets the payer's standards, the process enters the contracting phase.

*(**Note**: Experienced billing staff may use the term "credentialing" to also refer to the overall enrollment process. To prevent confusion, the Billing System materials will only use "credentialing" to mean the first step in the enrollment process.)*

4.3 Contracting

Contracting establishes the legal relationship between the successfully credentialed applicant and the third-party payer. Among other things, the contracts themselves specify the terms of the relationship and how the payer does business.

Receiving an approved contract from a payer completes the enrollment process. The applicant is then known as an "in network" participating provider (PAR). The provider can then file claims and receive payments subject to the terms of the contract.

4.4 The Enrollment Specialist

To help the LPHA select the right person, either from the existing staff or from outside the organization, a job description for an enrollment specialist is included in the Resources section of this manual.

As it relates to the enrollment specialist, unless the department is constantly enrolling new providers, enrolling with new payers or continually dealing with changes of HIV, STD, and HCV service locations, this will probably not be a full-time job. If this is the case, a possible solution is to consider combining the enrolling responsibilities with the billing functions.

After reviewing the Billing section of this manual, the department will have a better idea of what will be required of a billing specialist. Then it can make an informed decision regarding the possibility of combining the enrolling and billing responsibilities. For reference, a combined job description for an enrollment/billing specialist is also included in the Resource section of this manual.

Section 5: Credentialing

As mentioned above, credentialing is a process in which detailed information on an applicant is gathered and submitted to a third-party payer for approval. The goal is to be approved and contracted as one of the payer's "in network" participating providers (PAR).

Reviewing and verifying applications is not something payers take lightly. They give applications detailed inspection and analysis because they view the credentialing process as the cornerstone of their risk management and fraud prevention programs. Being detail oriented, thorough, and demanding helps payers protect themselves, the public, and their associated providers from a broad range of possible liabilities.

5.1 The Application Package

An application for acceptance by a third-party payer is actually a package of various components. The package typically consists of a completed application form, or a link to a completed online database application, and assorted supporting documents and certificates. These latter items generally relate to the applicant's identity, education, professional credentials, and worthiness.

The package also demonstrates such things as proper and current licensure, board membership and standing, and compliance with required federal and state programs such as registration with the Drug Enforcement Agency (DEA) and the Iowa Board of Pharmacy (CSA). It also can disclose malpractice suits, claims history, license restrictions or sanctions that have been imposed.

Consequently, when viewed as a whole, the application package presents comprehensive information that may reflect on a healthcare provider's ability to practice and professional competence. This places a significant responsibility on the credentialing specialist to be detailed, thorough, and accurate when the package is prepared.

The specific contents of an application package will depend on the requirements of the individual payer. To help avoid omissions and delays, visit the payer's website or get in touch with the payer's credentialing contact. Doing this before starting to assemble the information for an application package will save time and money.

5.2 Universal Credentialing Applications

The Iowa Statewide Universal Facility and Practitioner Credentialing Applications (the Universals) are used by a number of insurance companies to assemble provider and facility information for credentialing.

Universals are used by Wellmark Blue Cross Blue Shield, Midlands Choice, InterPlan, and TriCare. These forms are excellent tools for gathering and organizing the information insurance companies require when evaluating applicants to become participating providers.

The Universal applications can be downloaded on the Iowa Medical Society website: www.iowamedical.org under Resources, Iowa Credentialing Coalition, Forms.

5.3 Council for Affordable Quality Healthcare: CAQH

CAQH is a web-based repository for medical provider credentialing data. It's an important part of the credentialing process. The following insurance companies routinely access this Internet database to obtain information required for initial credentialing and periodic re-credentialing:

- United Healthcare
- Multiplan
- Aetna/Coventry
- InterPlan
- Humana
- Comp Psych
- Iowa Medicaid MCO plans
    - UHC Community Plan
    - Amerihealth
    - Amerigroup

Midlands Choice will accept a pre-printed CAQH form with provider data, but will not go to the database to download the information.

Participating insurance companies require that all data fields in the CAQH application be completed for each provider being enrolled.

5.4 Tax I.D. Number

A Tax I.D., also referred to as an Employee Identification Number (E.I.N), is required for an LPHA to be credentialed. Each LPHA should have a Tax I.D. number. It is common for county Local Public Health Agencies to operate under the county's Tax I.D. number. Finance or accounting departments can verify this information. If the LPHA does not have a Tax I.D. they will need to obtain one from the I.R.S.

5.5 Taxonomy Codes

Taxonomy Codes are part of a numeric administrative code system. This number indicates the type or medical specialty of a practice or provider. Codes are divided into two fundamental lists:

- Individuals or Groups (of individuals) or
- Non-Individuals (entities rather than people)

Selection of a taxonomy code is required when applying for a National Provider Identifier (NPI) number. A taxonomy code number is required on claims for Iowa Medicaid.

When applying for organizational and individual NPI numbers, applicants will be asked to provide information about the LPHA and its providers. One requirement is to indicate the Taxonomy Code. If the LPHA Taxonomy Code is unknown, the following web site will be helpful in determining the LPHA's appropriate code:www.wpc-edi.com/taxonomy.

The "Healthcare Provider Taxonomy Code" website provides an extensive list of provider and specialization descriptions. There are specific codes for individual provider types. Some are for MDs and DOs and others are specifically for PAs and ARNPs. These are used when credentialing an individual provider.

There are also non-individual or entity codes. These are used for facility or LPHA credentialing.

When choosing a taxonomy code, follow the instructions on the Taxonomy Code website.

5.6 National Provider Identifier: NPI Number

National Provider Identifiers (NPI) are issued to MDs, DOs, ARNPs, and PAs by the federal government. NPI numbers were created

with the inception of the HIPAA Privacy Act to replace the former Unique Physician Identification Numbers (UPIN) formerly used by Medicare to identify providers.

There are two types of NPI numbers – individual and organizational. NPI numbers are obtained from the National Plan and Provider Enumeration System (NPPES), a federal government organization. Each provider must have an NPI number to bill.

Organizational NPI numbers are assigned to groups or organizations. Each LPHA will require at least one organizational NPI and in some cases, LPHA may have two. This will depend on the scope of services being provided and the contracting requirements of individual insurance companies.

When a provider or organization applies for an NPI, NPPES creates and maintains an application file on its website. It is important to keep this information up-to-date.

Payer organizations routinely check this information to assure it matches data supplied in new or renewal enrollment applications. If the information does not match, applications will be returned and will not be processed until the information is updated. NPI data changes are made by going to the NPPES website at: https://nppes.cms.hhs.gov.

An NPI username and password are provided for each NPI number. It is important to secure and retain the usernames and passwords. They will be required to update provider information on the NPPES website.

5.7 Supporting Documents

There is a lengthy list of supporting documents needed for credentialing with insurance companies. Some may not apply to all provider types. (MD, ARNP, etc.)

- Proof of Tax ID number (IRS Form CP575)
- Form W-9
- Iowa license to practice
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate for foreign graduates.
- Professional school diploma
- Undergraduate diplomas
- Board certificate(s)

- Internship certificate(s)
- Residency certificate(s)
- Fellowship certificate(s)
- DD-214 for prior military only
- Photocopy of driver's license
- Copy of individual NPI notification
- Individual NPI username and password
- Organizational NPI username and password
- CAQH username and password (If previously established)
- Federal drug license certificate (DEA)
- State drug license certificate (CSA)
- Malpractice insurance policy cover/face sheet
- Malpractice claim history; written explanation of any previous malpractice cases with description of disposition
- CLIA certificate, if applicable
- Copy of provider's curriculum vitae
- Names and contact information of three healthcare professional references of similar degree
- Provider back-up name and contact information

5.8 Re-Credentialing and Updating CAQH

Credentialing is an ongoing process that requires LPHA to periodically update information. Each payer's re-credentialing schedule differs; usually every two to three years. Providers utilizing CAQH must update their files on the Internet on a quarterly basis. They must verify that this has been done. This will ensure that the provider's information is 100% up-to-date when an insurance company downloads their data.

5.9 Most Common Third-Party Payers

As an LPHA begins the credentialing process it is important for them to be aware of the most popular third-party payers in the state. They are Iowa Medicaid and their three MCOs, which include Amerihealth, Amerigroup, and UHC Community Plan. Also included are Medicare, Wellmark Blue Cross Blue Shield, United Healthcare, Aetna, Coventry, Humana, Multiplan, InterPlan, and Midlands Choice. As a result of the Affordable Care Act, the Iowa Healthcare Exchange currently includes two plans that are available state-wide. There are also three regional plans available. It is recommended that LPHA undertaking an insurance billing program enroll with as many of these payers as possible.

5.10 Facility vs. Individual Credentialing

Credentialing processes vary from one insurance company to another. While required information and documentation may be similar, processes are very different. The credentialing options include: individual, group or facility, or a combination of both. Some insurance companies offer both options, while some, like United Healthcare only offer individual credentialing of providers. However, all third-party payers offer individual provider enrollment

Individual enrollment allows MDs, DOs, ARNPs, and PAs to be credentialed and contracted under their individual NPI numbers. This process links the provider's individual NPI number to the LPHA's organizational NPI and Tax I.D. number. When completed, the provider is granted PAR status.

United Healthcare and Midlands Choice only offer individual credentialing status. This method of enrollment would be used to credential a practitioner providing direct services to patients. Also, a Medical Director issuing standing orders can be credentialed on an individual basis.

Services performed under standing orders should be billed under the Medical Director's NPI number, which is linked to the LPHA's organizational NPI and Tax I.D.

Group or facility credentialing is not offered by all insurance companies. This option involves credentialing the organization rather than individual providers. If an LPHA only delivers services under standing orders, this would be the best choice when enrolling with payers that offer this option.

LPHA do not represent the common business model for providing healthcare services, therefore, they are treated differently by some insurance companies. It is essential to verify each payer's credentialing requirements for LPHA.

5.11 Processing Time

Most insurance companies require 60 to 90 days for the credentialing and contracting processes to be completed. However, guidelines of many allow up to 120 days. There are also some exceptions that take even more time for completion.

Many applications require inclusion of a requested effective date. This date indicates the date of service the provider would like to use as a start date. Include a preferred date on the application, but there is no guarantee that it will be honored. In most cases, the insurance company will ultimately designate the effective date.

Medicare will routinely "retro" payments to 30 days prior to the date the application was received. Most private companies do not do this. If an effective date that is later than the application date is requested from Wellmark Blue Cross Blue Shield, they will usually recognize and grant the desired date. They are more likely to retro charges if the provider is already enrolled or has previously been enrolled with them under a different Tax I.D. number. United Healthcare never grants an effective date that is prior to the date on which the contract is issued, which is at the end of the enrollment process.

It is important to verify with the insurance company credentialing staff of each payer to determine if the retro date applies. If patients are seen during this pre-credentialing time and the insurance company does not "retro" payments, it may be necessary to write off potential payments for services rendered. It is important to be cautious about seeing patients before the effective date is known.

5.12 Credentialing Tips

Credentialing is the foundation of initiating a medical billing program. It must be a well planned and executed process. It is important to consider the following:

- All insurance companies maintain a staff dedicated to processing credentialing applications. LPHA staff should work to establish positive working relationships with these specialists.
- Before starting the credentialing process, make certain all the information and documents needed to complete the process are collected. Don't start until everything is ready.
- Before submitting applications double-check everything for accuracy. Mistakes can cause lengthy delays and even being required to re-start the process.
- The LPHA and providers will need to be re-credentialed every three years. This requires all information relating to the facility and providers to be kept current. Communications with providers and other LPHA staff to keep information current and organized should be a

priority. If CAQH is kept up to date, it can be used as the template of information required for re-credentialing

- Everything related to credentialing is subject to change. The rules, forms, and insurance company contracts are subject to change. When beginning credentialing or re-credentialing, always confirm that the most common forms are being used.
- Attention to detail is paramount. For example, Medicare requires original signatures and they prefer blue ink. Stamped of photocopied signatures are not acceptable. A few companies will accept signed applications that have been scanned, emailed or faxed. Always know the rules before submitting an application.

Section 6: Contracting

The contract between an LPHA or an individual provider and a third-party payer/insurance company is used to accomplish the following:

- Establishes a legal relationship with the third-party payer.
- Defines the provider's responsibilities when delivering services to plan members.
- Establishes the claim filing process.
- Details the procedure for the issuance of payments.
- Defines the fee schedule; which sets the amount an insurer will pay for each CPT code billed by the LPHA.
- Details requirements regarding co-payments, deductibles, and other factors affecting the LPHA billing program.

6.1 The Contracting Process

Contracting with most insurance companies is well defined; however the process of getting a contract will vary from company to company.

With some third-party payers like Wellmark Blue Cross Blue Shield or Midlands Choice, contracts are either downloaded or ordered from the company prior to completing the credentialing forms. With others, like United Healthcare, the contracts are delivered after approval as a participating (PAR) provider. LPHA staff will need to research the insurance company websites to determine how and when to access the contracts.

6.2 The Welcome Letter

Enrollment is complete when the LPHA receives a welcome letter from the payer. All insurance companies confirm PAR status with such a letter.

The welcome letter will include the official "effective date of service" for each plan along with a copy of the signed contracts and a fee schedule. With Wellmark Blue Cross Blue Shield, the LPHA will be enrolled for inclusion in several different insurance plans. This is also true for United Healthcare. Some of the plans may have different effective dates, even if they are from the same company. Be sure to check all effective dates and when beginning

the billing process, coordinate the scheduling of patients according to individual plan start dates.

Most insurance companies will be hesitant to offer the contract effective date in advance. In some cases, the effective date may actually be several weeks after receipt of the welcome letter. Even if an insurance company representative provides an effective date over the phone, the official date is the date stated in the welcome letter.

6.3 Out-of-Network Providers

In rare instances, it is possible to receive reimbursement from some insurance companies when the provider or LPHA is not PAR, but is considered an "out-of-network" provider. When out-of-network providers receive compensation for services, it is significantly less compared to a PAR provider, if payment is received at all. Generally, if out-of-network, the LPHA will not be paid. In some cases, an insurance company will send the out-of-network payment directly to the patient. The LPHA will need to collect payment from the patient. Generally, this is not an easy task. Often, patients are required to meet pre-established deductible amounts before being eligible to receive reimbursement for services delivered by an out of network provider. If a patient has not met the deductible; providers are faced with billing the patient or writing off the charges to bad debt or collections.

Section 7: Billing

With the completion of the enrollment process, and the reception of the welcome letter and effective date, the LPHA can begin billing third-party payers for HIV/STD/HCV services it delivers to covered patients. But, what is medical billing all about?

To most people, the answer is likely to be something akin to simply sending in claims and receiving payments. All the "little things" that have to be done along the way are often overlooked.

7.1 What Is Medical Billing? - An Overview

To understand what billing involves, all the steps must be properly identified and put in sequence. When this is done, many will be surprised at how complex and detailed the process is. Chances are they will also be surprised when they see how early in the patient communication and treatment sequence, the billing process actually begins. It starts long before the claim is calculated and submitted.

The sequence of steps described below illustrates the billing process. It is applicable whether the department operates in a traditional clinical setting that utilizes pre-set appointments, or focuses on delivering services on a walk-in basis such as an off-site HIV, STD, HCV testing site.

- **Appointment Setting**

  In a typical clinical setting, the billing process begins with the appointment setting process. That's when information about the patient and the reason for the visit is first discussed and either written down or entered into a computer system.

- **Patient Registration - Intake**

  In a walk-in setting, the billing process begins when the patient walks up to the registration desk and is greeted and registered.

  The registration process, including determination of payment resources and/or qualification for hardship policies is detailed in Sections 2.2, 2.3, and 2.4 of this manual.

If the patient is covered by some form of healthcare plan, the coverage for the service(s) to be performed is typically checked at this point (pre-authorization/verification). If a copay is due, it should be collected before service is provided.

Sometimes coverage cannot be verified or pre-authorized. In such a case, the LPHA will need to determine whether and how to proceed.

*(**Note**: This is the type of situation that should be anticipated in the LPHA's policies and procedures manual.)*

When everything is complete and has been noted or entered into the computer, the patient's demographic details and information required for treatment are passed to the medical staff.

- **Patient Encounter**
  The provider reviews the information gathered during registration and the patient's chart, if available. Then after evaluating the patient, the provider delivers the appropriate service(s).

  During or following the patient encounter, the provider notes the service(s) delivered and codes them using a table of standardized diagnostic and procedure codes. These codes are required when creating a billable claim.

  Depending on whether the services were paid for in advance, the information is either routed to the patient checkout staff or directly to billing.

- **Patient Checkout**
  If the patient didn't pay for the service(s) in advance and is responsible for payment, the list of coded services delivered is reviewed, a total due is determined, and payment is secured from the patient. The patient is then released with any instructions issued by the provider.

  Depending on the LPHA's procedures, the payment is passed to the accounting or billing areas. Regardless, the information relative to billing must be routed to the billing department.

- **Claim Filing**
  The patient information, service descriptions, and coding are logged by the billing department or entered into the billing software. The information is then reviewed for errors (scrubbed), and a claim is created. This claim will be filed with the third-party payer either by sending a paper form or using a computerized billing system.

  Occasionally a claim may be denied. This is often an indication that the payer may need additional information, a correction made or that the patient may not be covered for a specific procedure. When notified, this must be handled immediately. Appeals are possible if a claim is ultimately denied, but the LPHA feels the denial was in error.

- **Payment Reconciliation**
  When the claim has been approved, a payment will be issued either by check or electronically. When the claim is paid, an Explanation of Benefits (EOB) is issued that spells out how the payment was calculated.

  On receipt of the payment and EOB, the department reconciles the amount received against the claim, applies the amount received to the patient's account, and balances the books.

This outline is a good basic representation of the medical billing process for a single claim. When examining the process, it's clear that billing, with all its nuances, can be complex and challenging. It should also be clear that a lot of pre-planning and work goes into the process before the first bill is sent. This pre-planning is, in large part, what determines the success of a billing program.

All this is a lot easier to understand if the process is broken down into a manageable list of interrelated functions as noted above. In doing so, it will become clear that some LPHA already have what is needed to start a successful billing program. For others, this discussion will prepare them, so they can take the steps necessary to get their program up and running.

The billing process includes logistics, staffing, training, technology, and development and execution of operating policies and procedures. The following information will help LPHA make constructive and informed decisions regarding implementation of a third-party billing program.

7.2 Preparations for Billing

There are two keys to success when operating an insurance billing program: patient flow and work flow. Carefully consider the process of efficient patient care while obtaining all required information to bill an insurance company.

The LPHA must have a cash payment program in place. Insurance companies require routine collection of co-payments and co-insurance. Every effort should be attempted to make these collections at the time of (prior to) service. Therefore, having debit and credit card as well as cash collection capabilities is a requirement.

7.3 LPHA Logistics

The physical location where billing tasks are performed is a common obstacle for LPHA. Staff must consider the process of efficient patient care while obtaining all required information to bill the insurance company. And, HIPAA Privacy of patient information must be followed at all times. It's not uncommon for the protection of privacy at the reception desk to be an ongoing challenge.

An LPHA must continually make its best efforts to protect patient privacy. However, this should not become an excuse to avoid implementation of a billing program. The use of a specially trained individual such as a Patient Advocate to handle the private conversations with patients, rather than using the receptionist is one viable alternative. However, some LPHA do not have the staffing budgets to allow for a more than a receptionist. In these cases, the LPHA must work with what they have available.

7.4 Computer Hardware

Some LPHA are filing Medicare Immunization claims on paper forms. This is only allowed for immunization billing when an LPHA is enrolled as a Roster Biller. HIV, STD, and HCV claims must

be filed electronically to Medicare and all other payers. Therefore, appropriate computer hardware and software are required for billing.

Daily filing of claims will require a relatively new, robust personal computer (PC). Also, all billing information should be backed up.

Be careful of purchasing Apple/Mac platforms such as I-Pad or MacBook computers. A very limited number of billing software vendors support Mac products for billing. Also, most IT departments are more supportive of the Windows PC systems.

Billing will involve extensive use of the Internet. Logging on to a remote server owned by the LPHA's billing software vendor will likely be a part of the daily routine. Also, searching insurance company websites to verify patient benefits, co-pays, etc. will be among the daily activities for LPHA staff members.

7.5 Computer Software – EHR and Practice Management

The selection of software to assist with the billing process can be challenging and expensive. The marketplace is flooded with vendors competing for business. Unfortunately, that does not mean the competition is driving down prices.

There are two classifications of software to consider: Electronic Health Records (EHR) and Practice Management systems (PM). EHR software is generally used for charting patient history and the storage and retrieval of patient medical records. PM systems are used to implement the billing process.

A PM system is often part of an EHR system. Some information in a PM system and an EHR may overlap. The EHR system is generally used to assist the LPHA with tracking clinical matters. The PM system is used to manage administrative and financial matters.

An EHR program is a systematic collection of electronic health information about individual patients. These records include demographics, medical history, medication history, allergies, immunization status, laboratory test results, radiology images, vital signs, and personal stats like age and weight.

EHR software provides a complete record of patient encounters. It streamlines workflow and increases safety through evidence-

based decision support, quality management, and outcomes reporting.

It is entirely possible to manage an insurance billing program without an EHR system. However, unless the billing process is outsourced, a PM system will be required. In most cases, it will be beneficial to use both types of systems.

PM system software assists with the management of day-to-day operations of a medical practice. The software allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, retain and apply the LPHA's fee schedule to individual claims, perform billing tasks, post payments to patient accounts, follow up on denied claims, and generate reports.

Most PM systems are designed for small to medium-sized medical offices. Some software is designed for or used by third-party medical billing companies.

EHR and PM systems are sometimes divided among desktop-only software, client-server software, or Internet-based software.

- **Desktop Software**
  The desktop variety is intended to be used only on one PC by one or more users who share access. This option is no longer widely used.

- **Client-Server Software**
  Client-server software enables multiple users to share the data and workload on software that has been installed on a county-owned or LPHA-owned and operated server. The server can be accessed by multiple PCs on the local computer network. While very popular at one time, this hosting method has lost popularity with improved access to the Internet. The cost to maintain servers and service the local network has largely been replaced with low cost cloud-based servers accessed via the Internet.

- **Internet-Based Software**
  Internet-based software has become the most commonly used form of delivery for both PM and EHR systems. This solution decreases the need for the LPHA to run their own server and provide their own security and reliability.

  With this system, the LPHA biller logs on to a remote server where all data is stored. An unlimited number of employees can access the remote server. Usually this

server is owned and operated by the software vendor. A fee, often based on the number of independent users or the number of healthcare providers in the LPHA, is paid each month. This delivery method is usually referred to as "cloud-based."

7.6 Selecting the Best Software Tools

To be cost efficient and increase efficiency, it is important to consider the following when selecting a PM system:

- Integrates properly with LPHA workflow
- Contains features that simplify the process for the billing staff
- Is well supported by the vendor. The ability to get a fast response to a problem with a minimum of red-tape is vital to the long-term success of a PM system
- Meets all government requirements for reporting of quality data required by Medicare/Medicaid

Features to consider in a PM system:

- Capturing Patient Demographics – The system should provide an easy-to-understand module for data entry of patient demographic information.

- Appointment Scheduling - This is a vital function for LPHA operating in a clinic setting where advance appointments are set over the phone or Internet. The software should allow for time slots that vary in length, to accommodate various types of patient visits. It should also be easy to learn.

- Maintaining Lists of Insurance Payers – Whenever a patient's insurance information is entered into the computer system, it should be permanently saved in the system's database. When insurance addresses are accumulated over time, they create a valuable data source that reduces future data entry.

- Maintaining the Fee Schedule – The LPHA fee schedule will be maintained permanently in the system. It should be easy to add new codes and prices. Also, as codes are added, the system should automatically generate the names or the

codes. These will be used to print a description of services provided on patient statements.

- Processing Claim Data (CPT/Diagnosis Codes) – All PM systems organize claim data into the proper format for submission (billing) to third-party payers.

- Performing Billing Tasks/Electronic Claim Filing – This refers to the actual submittal of claims to a third-party payer or clearinghouse.

- Claim Scrubbing For Errors – Claim scrubbing helps identify errant or missing data before it is sent to a payer. This function saves time and helps generate quicker payments.

- Provide a Clearinghouse Connection – Many PM vendors either own or are affiliated with a billing clearinghouse. Many LPHA choose to send claims through a clearinghouse, rather than billing direct to each individual third-party payer. The pros and cons of this will be discussed later in the paragraph labeled: Clearinghouse.

- Electronic Payment Posting – This is a basic function provided by all PM systems.

- Claim Follow-up - PM systems vary widely in the types of follow-up systems they offer. The best systems help identify claims that have not been paid in a timely manner. This allows the billing staff to take the necessary actions to secure payment for unpaid or incorrectly paid claims.

- Generating Administrative Reports – Robust report writing is a valuable tool to any medical practice. The range of reports available should be wide and they should not be difficult to extract from the system. There should be a list of standard reports available. The user should also be able to generate custom reports.

It is best to establish a list of all LPHA staff that will be involved in using the system. Include everyone involved in both the clinical and administrative processes.

The next step is to make a short list of possible vendors. Iowa's LPHA are currently using several different vendors worth mentioning. This is not intended as an endorsement. These are just a few options available.

- Some LPHA are using a free EHR product known as Practice Fusion. Rather than charging users a fee, advertising appears on the screens within the software. This system was designed specifically for use in smaller medical offices, which makes it work well in the public health. Practice Fusion has partnered with a couple of Billing Outsource Vendors that can also provide the LPHA with PM systems. In return, the LPHA pays a monthly fee to outsource the billing process. It is not required that an LPHA use one of these PM systems in order to use Practice Fusion. The LPHA can provide their own billing or they can outsource to any available resource of their choice.

- During implementation of a CDC Billing Project related to childhood immunizations, 14 Iowa LPHA purchased an EHR/PM system package from Minnesota-based Champ Software. It's called Nightingale Notes. This company offered discounts to Iowa's LPHA and continues to provide ongoing support to its Iowa users.

The next step is to conduct an on-line demo of each product. Most vendors will provide an Internet-based presentation moderated by a sales representative or a software trainer. In some cases, software vendors work with local companies that sell and provide service for their products. These vendors are usually willing to come on site and provide a live presentation.

Once the selection of a PM System is completed, the appropriate time and resources required to get the new system up and running will be substantial. As with any new software, there is a learning curve. The training received from the vendor will provide the basis for how staff will process insurance claims. The PM System training should include every step of the billing process. In essence, a good PM System training program will give the LPHA billing staff all the tools and information necessary to bill and collect insurance claims efficiently and effectively.

The acquisition of EHR and PM software is one of the largest financial commitments required to launch an insurance billing program. Most software vendors are willing to negotiate the fees for use of their programs.

7.7 Staffing/Job Descriptions

Regardless of the task at hand, hiring qualified employees is always crucial. If possible, hire experienced staff.

In many cases, LPHA will be using existing staff to launch the billing program. If this is the case, it is important to ensure people selected to do various jobs have the necessary skills to accomplish all that needs to be done. The required tasks can be broken down into four categories, recognizing that there may not be four positions available to accomplish these tasks. If broken down by job title, the four would be:

- **Reception/Intake Specialist**
  Excellent people skills are required. Organizational skills are equally as important. The Intake Specialist must collect and organize all the necessary information and organize it into a legible set of documents. Working with a wide range of forms and obtaining patient signatures are also important tasks. This individual will collect insurance and other information from patients. If the patient is not the responsible party listed on the insurance, staff will need to obtain the name and date of birth of the insured individual. Obtaining a photocopy or scanned image of the front and back of the insurance card is also required. Explaining HIPAA privacy and having HIPAA authorizations signed is also very important.

- **Patient Advocate**
  Conducting an in-depth conversation with the patient to determine their medical needs and financial capabilities is key to this position. Checking to verify the patient's insurance coverage is also part of this job. If necessary, delivering an explanation of hardship policies and qualification for hardship may be done. Medical knowledge, strong people skills, and organizational abilities are key to this position.

- **Enrollment/Credentialing Specialist**
  Fulfillment of the enrollment process is the primary responsibility of this person. Tremendous attention to detail is essential. Also, the tenacity to follow up with insurance company staff to push applications to completion is a routine requirement.

- **Billing Specialist**
  A broad base of knowledge covering coding, billing, insurance plans, software systems, and all other aspects of the billing process is required. Commitment to getting each and every claim paid is a valuable asset in this position. Of all the positions, this one will benefit most from having solid experience.

- **Enrollment/Credentialing & Billing Specialist**
  A dual responsibility for lower volume situations. See enrollment and billing specialist descriptions, above.

Depending on the size of the LPHA and available resources, a single person may be required to fill multiple roles. Regardless of the staff count, each responsibility requires very specific skills, knowledge, and abilities. Sample job descriptions are included in the Resources section of this manual.

7.8 What Services To Bill

Those LPHA in Iowa currently providing HIV/STD/HCV services have developed a list of services they perform. Some or all of those may be billable depending on the payer(s) the LPLHA is enrolled with.

If, at some time, the LPHA is ready to expand list of services, it will need to check with the payers it is enrolled with to determine which services are billable.

A comprehensive list of potentially billable services is included in the Resources section of this manual.

Note: The scope and enrollment of individual providers will determine what codes are payable.

7.9 Establishing a Fee Schedule

Creating a fee schedule for services in an LPHA can sometimes be challenging. Private physician offices are set up to make a profit on all services. Local Public Health Agencies exist to serve a different purpose. However, in today's financial environment, it is helpful for everyone, private and public, to generate revenue as a means of sustaining existing programs and perhaps adding new ones.

Understanding how insurance company reimbursements work will help with establishment of a fee schedule. For example, Wellmark Blue Cross Blue Shield may allow payment of $40 for a specific code/service. If an LPHA bills that code and charges $40, the patient's co-payment and the amount paid by insurance will total $40. This is known as the allowed amount. If the LPHA bills a fee that is more than the allowed amount, in this example, the total paid will still only equal the $40, because that is all that is allowed.

The allowed amount will vary from one insurance company to another. For example, if Wellmark allows $40 for a specific code, Midlands Choice may allow $39, Medicare is likely to be around $25 and Iowa Medicaid will be closer to $19. This is why it is financially beneficial to be able to treat patients with any type of third-party coverage as apposed to just seeing Medicaid patients.

The difference between the amount paid and the amount billed is the contractual adjustment. The LPHA must adjust off the difference and accept the allowed amount printed on the payer's fee schedule as payment in full.

If the LPHA charges a fee that is less than the allowed amount, the insurance company will only pay the amount billed. They do not adjust the fee up to the published allowed amount, resulting in the loss of LPHA revenue.

The level set for fees is entirely up to the LPHA. One way to establish fees is to obtain the fee schedules from Wellmark Blue Cross Blue Shield and/or Midlands Choice. If the LPHA is contracted with these payers, they should have received a copy of the fee schedules. These insurance companies are among the highest paying in Iowa.

Using the list of CPT codes that will be billed by the LPHA, create a list of the higher of the two company's fees for each code. Then multiply that number by a percentage to establish the fee. Generally, private medical practices will multiply times 120 percent or higher. Some LPHA will establish fees lower than that, while some even set their fees below the highest allowed amount. By setting fees above the highest allowed amount, the LPHA assures that they will never lose money by under billing. Of course, the higher the percentage, the greater the adjustment or write-off amount will be.

When the fee schedule has been established, it will be entered into the PM system set-up database. This will allow the billing staff to enter a CPT code and the system will automatically pull the correct fee and apply it to the claim being processed.

Commercial insurance companies and government payers advise against having more than one fee schedule. Medicare takes this very seriously. Never charge Medicare one price and uninsured patients a lesser fee. The correct way to do this within the boundaries of most payer contracts is through the implementation of a Hardship Policy. When the terms of the LPHA's hardship policy are applied, it is acceptable to adjust the amount charged to an uninsured patient at a level that's in compliance with the hardship policy and below the amount allowed by Medicare. For further information, refer to the Hardship Policy in Section 2.3 of this manual.

7.10 Billing Documents

There are numerous electronic and paper forms required to complete the billing process.

If using an EHR system and/or a PM system, much of the documentation is created and stored on the computer. It is never printed. Scheduling, check-in, insurance verification, scanning of insurance cards, coding, and charts are all created and stored on the computer system.

Whether using electronic systems or not, there will be a need to create the contents for documents discussed in the upcoming paragraphs. The billing staff will use that information to populate either computer forms or paper forms. If using software to manage these activities, the initial software training should instruct the LPHA staff how to create these forms within the computer system.

7.11 Superbill/Charge Ticket/Encounter Form

The terms superbill, charge ticket, encounter form are generally interchangeable. This is the form used to record the services being received by patients. Typically, it is a log sheet where the healthcare providers check a series of boxes to indicate services provided to the patient and an explanation of why these services were provided. If using an EHR system, the superbill document will reside on the computer and will be completed by the healthcare provider on the computer. Without an EHR, the same tasks are accomplished manually and then the data is manually entered into the PM system by the billing staff.

7.12 CPT, HCPCS, and Diagnosis Coding

All medical procedures performed during the patient visit are reported using a coding system. There are four commonly used types of codes: CPT codes, ICD-10 diagnosis codes, modifiers, and HCPCS codes.

The codes used to explain what the healthcare provider did are called CPT, Current Procedure Terminology, codes. In general terms, providers use two types of CPT codes: Evaluation and Management (E/M) codes, and Procedure codes.

E/M codes are used to describe the general patient visit. There are several levels of E/M codes to designate the time spent and level of decision-making required. E/M codes are often accompanied by the other classification of CPT code known as a Procedure code. Procedure codes describe specific procedures that are performed in addition to E/M codes. The LPHA's superbill should display all of the codes necessary to describe the procedures that will be performed.

The superbill should also include modifiers. Modifiers are a different type of numerical code used to cover a wide range of topics that add information to the claim to help insurers determine how or whether or not the LPHA should be compensated.

Diagnosis codes are called ICD-10, International Classification of Diseases Tenth Revision, codes. They are used to describe the primary complaint of the patient or why they are being treated. There is a diagnosis code for every possible medical condition.

Healthcare Common Procedure Coding System or HCPCS (often pronounced hick-picks) codes use alpha and numeric characters to describe certain procedures and drugs.

Coding books can be purchased to help staff select or verify the correct codes. On-line services are available to answer coding questions such as www.CodeItRightonline.com. Also, many coding issues can be resolved by simply doing a Google search for questions.

When creating a superbill, it is necessary to work closely with the LPHA's healthcare providers to determine exactly what procedures are going to be performed. Then match those procedures to the correct CPT codes. Next, create a list of the most common diagnosis codes that are likely to be used. Because LPHA that deliver HIV/STD/HCV services generally have a limited list of services available, the resultant superbill will not be overly complex.

If the LPHA is using an EHR system, make sure to include the contents of the coding list in the set-up of the software. Then, providers will be able to simply point and click to complete an electronic superbill that will automatically populate certain fields in the PM system for billing.

If the LPHA is not using an EHR system, the same coding information is used to create a paper superbill. If creating a paper superbill, it is common to develop it using an Excel spread sheet. Typically, on a paper superbill, the codes are all listed with boxes next to them so the provider merely has to check the appropriate boxes. The superbill should also contain an assortment of information to help identify the patient such as name, address, date of birth, and the payment amount collected at the time of service. There also needs to be a box to note the place and date of service. Both are required to be included on an insurance claim.

The Resources section of this manual contains a sample superbill designed specifically for LPHA that provide HIV/STD/HCV services.

7.13 Patient Registration/Demographic Form

It is essential to gather and maintain records of patient demographic information. One way to do this is to have the patients complete a Demographic or Intake form themselves. Much of the information gathered is necessary to file an insurance claim, or to help collect funds from patients on claims that are denied for payment by a third-party payer.

A sample Demographic Profile form is included in the Resources section of this manual.

If the LPHA has purchased EHR software or a PM system that includes a computerized patient scheduling program, much of the demographic information is entered into the computer by the receptionist when an appointment is made or when the patient arrives at the front desk. The rest should be gathered from the Demographic Profile form.

There are several other forms that are often included with the Patient Demographic form. Since these forms require a signature from the patient, have the patient sign them while completing the demographic form. These forms include

- Treatment Authorization
- Assignment of Benefits
- HIPAA Notice of Privacy Practices acceptance

Regardless of whether the LPHA is using an EHR system, it is still necessary to obtain the patient's signature on the documents listed above. Typically, these signed documents are then scanned into the computer system as part of the patient's permanent record. If the LPHA is working on paper, these documents should be included in the patient's chart.

There are samples of these documents as part of the Patient Demographic Profile form in the Resources section of this manual. Many LPHA are probably already using a document similar to this.

7.14 Hardship Policy

The important topic of hardship policies was discussed in 2.3 of this manual. Inclusion of a detailed hardship policy is an important element of any LPHA third-party billing program.

There are many uninsured and underinsured patients who seek medical care from Iowa's LPHA. For many, this is the only or last resort for medical care. Consequently, LPHA need to be prepared to provide reduced or no-cost services to patients that qualify for the hardship plan. It is important that all qualifying individuals are treated equally.

7.15 Policies and Procedures

All LPHA that are charging for HIV/STD/HCV services should maintain written policies and procedures to cover all aspects of patient encounters related to billing. It is vital to have a written plan to deal with the multitude of things that happen in the process of scheduling, greeting, and counseling patients, and collection of fees. Literally all elements of the patient encounter should be included in the policies and procedures.

It is important to make sure that all LPHA staff are well trained on policies and procedures. Continually monitor and amend the policies and procedures as they will always be a work in process, changing routinely, particularly as momentum is gained with the billing program.

7.16 Insurance Verification

Reading and interpreting the contents of patients' insurance cards is an important task for the staff. Information from these cards is needed by the reception and billing staff to determine coverage and co-payment requirements. The information on the back of the cards will tell the biller where the claim needs to be sent for processing and payment. The LPHA's policies and procedures should require that the receptionist or other designated employee copy the front and back of a patient's card on their first visit. Some insurance cards have colors printed on them that make it very difficult to make legible copies. If the person making the copy can't read the photocopy or scanned image, it is going to be necessary to make a manual copy of the information on the card. Every copy should be checked for clarity before the original is returned to the patient.

If a patient returns for additional services at a later date, the staff should always re-verify the information on their insurance card to be sure nothing has changed since the last visit.

Unfortunately, it is not uncommon for patients to present insurance cards that are no longer valid. When dealing with commercial insurances, it is fairly common for people to change jobs or even become unemployed. Always remember to ask patients to verify whether their insurance coverage has changed. Whatever the situation, it is not uncommon to end up with outdated and incorrect information. Many LPHA also utilize insurance company web sites to make sure that a patient's plan is in effect. These sites can also be used to determine co-payments and co-insurance that might be due. Having a formal process in place to verify the insurance plans of all patients is very important.

Medicaid patients must re-qualify for benefits on a monthly basis. If employment or income status changes, their coverage may no longer exist. With the Iowa Medicaid Modernization program, benefits are being processed through three separate managed care insurance companies. Adding to the possible confusion is the fact that Medicaid subscribers can switch back and forth between the three carriers. It is vital to go on-line to check benefits and determine which plan is active for each patient. For Iowa Medicaid, this can be done over the phone by calling 515-323-9639. Or, it can be done via the Internet at www.IME.state.IA.Us. Click on "Provider On-Line Tools." The LPHA staff will need to have signed up for Medicaid's provider on-line tools called "Total On-boarding" to complete the process. If the LPHA has established a billing connection with Medicaid, this sign-on was granted during the billing set-up process.

7.17 The Claim

The PM system organizes all data related to an insurance claim into a specific file format that is accepted by all third-party payers. Insurance claims are currently filed on an electronic derivative of the HCFA 1500 called the ANSI 4010A1.

The HCFA 1500 is a unique paper form previously accepted by all insurance companies to report claim information. Today the paper HCFA is still used to file secondary claims, however they can also be sent electronically. The ANSI 5010 form contains electronic loops and segments that require certain information to be completed. If information is missing or if there is an incorrect number, the claim will be rejected.

7.18 Co-Payment and Co-Insurance

Insurance contracts mandate the LPHA's responsibility to collect a co-payment. It is required that the appropriate co-payment be collected at the time of service. There is also a financial responsibility to the LPHA to collect this money when appropriate.

The patient's insurance card will tell the amount that is due. The receptionist will have to consistently and professionally request payment or implement the Hardship Policy.

The initial point of contact with the patient is the best time to successfully collect co-payments. Mailing invoices to collect these payments is expensive and is often unproductive. Collecting these co-payments is another important step in the insurance billing process that should be included in the LPHA's billing policies and procedures.

Patients will provide many forms of payment for services. Be prepared to receive cash, checks, debit cards, and credit cards. Also, some patients may offer health savings account cards. They are processed like a credit card.

Any time there are cash transactions involved, be sure there are strict rules of accountability in place. LPHA policies and procedures should require that all patients receive a written receipt for payments. Also, all payments should be routinely logged and the log sheet should balance against deposits on a daily basis. If possible, it is always a good idea to have more than one person handling, monitoring, and accounting for the cash receipts.

7.19 Information Flow

The flow of billing information from check-in, to a healthcare provider, to the Billing Specialist must be smooth and timely. The exact process will vary greatly depending on the level of computerization being used by the LPHA.

Regardless of the format, three things are required to file an insurance claim:

1. A fully coded superbill that includes CPT codes, ICD-10 diagnosis codes, HCPCS codes, modifiers, and a date of service.

2. A completed patient demographic form.

3. Information from the front and back of the patient's insurance card.

It is important to carefully outline the work-flow plan to assure that all claims are processed in an accurate and timely manner. Establish a deadline in which all claims will be filed after the patient has been seen. Forty-eight to seventy-two hours is a common and realistic goal. When the work-flow timeline has been established, include all the necessary activities in the Policies and Procedures manual.

7.20 Billing Staff Responsibilities

The Billing Specialist is responsible for organizing all claim information and compiling it into an electronic format that can be submitted to insurance companies for review and payment. Primary responsibilities fall into the following categories:

- Selecting and working with a clearinghouse
- Coding check
- Demographic data entry
- Claim/Coding data entry
- Electronic claim submission
- Claim follow-up
- Handling insurance denials/re-filing claims
- Filing claims with secondary insurance
- Payment processing and posting
- Client/patient billing
- Collection agency management/write-offs
- Responding to patient inquiries
- Report generation

Most vendors that sell PM systems provide extensive training on most of the procedures in this list.

Coding checks refers to the process of reviewing the provider's coding prior to entering the claim into the billing system. It is important to note that, in most cases, the biller should not change codes without consulting the provider. An action such as this would be considered non-compliant with rules and laws that govern medical billing. The exception would be if the biller is a certified coder and has access to the patient's chart to review notes related to the visit.

Responding to patient inquiries is self-explanatory. It is common for patients to have difficulty understanding statements they've received. In most cases, patients are calling for clarification. The billing person is the best equipped staff member to explain outstanding balances or the reason for the charges. It is a matter of providing good patient service.

Even with outstanding training from the software vendor, it is important to create a workflow that assures that all tasks will be completed routinely and in a timely manner. A major challenge with in-house billing operations is that staff becomes so involved with sending out new claims, the claim follow-up part of the job often is ignored. There will be claims where payments are denied for one reason or another. The only way to collect on those claims is to follow up with the insurance company to determine exactly why a claim was not paid. The follow up can take place on the phone, on insurance company websites, or both. When the reason for the denial is determined, the appropriate changes must be made and the claim must be re-filed.

There is a long list of reasons for denials. It might be that the patient no longer had coverage with the insurer, or perhaps the Diagnosis Code did not match up properly with the CPT code. In other cases, there may have been a need to add a modifier to the claim in order for it to be paid. In some insurance plans, preventative services are not covered. The list of reasons goes on and on. With practice, the biller will become familiar with these reasons for denials and he or she will catch the error in the data entry phase of the process, thus reducing the time needed for follow-up and re-filing. Improvement in this area will result in faster collections and better cash flow for the LPHA.

7.21 Electronic Claims/Clearinghouse

Practice Management (PM) Systems allow data entry of claims in batches. A batch can range from a single claim to hundreds of claims. There are no limits. Often, a biller will include all the claims from a day to make a batch. Batches are then submitted to third-party payers, through a medical billing clearinghouse. A clearinghouse is a business functioning as an intermediary between the LPHA billing staff and third-party payers re-transmitting claims to all third-party payers.

Clearinghouses are aggregators (senders and receivers) of massive amounts of insurance claim information, managed by software. Large clearinghouses process trillions of transactions annually. In essence, they are regional post-offices enabling healthcare practices to transmit electronic claims to insurance carriers.

Additionally, they provide billers or office managers a place, through an online control panel, to manage all their claims through one central location.

An LPHA biller using a PM system creates a batch of electronic claim files that is uploaded to a clearinghouse. The clearinghouse "scrubs" the claim, checking for certain types of errors or missing information. Once claims are clean and pass all the preliminary tests for approval, the clearinghouse securely transmits them to the specified payer that has established secure connections meeting HIPAA required standards.

Next, the specified payer will accept or reject the claim. A status report from the insurance company is sent back to the clearinghouse, updating the claim's status. The biller retrieves claim status reports from the clearinghouse, via the Internet. If rejected, the claims must be corrected and re-submitted.

The successful transmission results in the LPHA's receipt of a reimbursement check along with an explanation of benefits (EOB). The EOB details charge amounts, payments, adjustments, and any remaining amount due from the patient or a secondary insurance payer on all claims. More information on electronic remittance will be provided in the Section 7.21 of this manual titled Receiving Payments.

Dozens of medical clearinghouses provide the same basic service; scrubbing claims and secures transmitting of electronic claims to insurance companies. There are many benefits in utilizing a claims clearinghouse:

- Allows staff to identify and correct errors early in the billing process.
- Results in fewer rejected claims allowing for significantly higher claim success.
- Submits claims electronically reducing reimbursement times.
- Eliminates the need for manual preparation of claims.
- Submits all electronic claims in a single batch at once, rather than to each individual payer.
- Provides a single location to manage all electronic claims.
- Decreases staff time to resolve claim issues.
- Allows LPHA billing staff access to knowledgeable support people quickly and efficiently.
- Creates shorter payment cycles leading to improved cash flow.
- Reduces or eliminates the need for paper forms, envelopes, stamps.

Clearinghouses offer additional features that provide a powerful level of information regarding revenue cycle management.

These features may include:

- **Electronic payment** – automatically updates accounting on payment of claims. A fee is often charged for this service.
- **Claim Status Reports** – provides an up-to-date status of a claim.
- **Rejection Analysis** – reports error codes in an understandable format.
- **Online Access** – allows editing and correction of claims online, day or night.
- **Printed Claims** – prints claims to paper automatically when the provider is not PAR with the insurance company.
- **Patient Statements** – printed and mailed at a cost usually less expensive than LPHA processed statements.
- **One-on-one support** – delivers training from billing experts.

There is a volume-based fee to use a clearinghouse. In most cases, the fee is based on the number of claims or the number of providers in the LPHA. Typically, clearinghouse services and costs are comparable to sending paper claims and processing patient statements in-house.

Using a claims clearinghouse simplifies claims processing. It is possible to file direct to payers. Larger payers such as Medicaid, Medicare, and Wellmark Blue Cross Blue Shield work with their own intermediaries, allowing submission of claims direct to them.

There are disadvantages to direct claim filing. First, establishing individual electronic connections can be expensive. Check with the

LPHA's PM vendor for quotes. Secondly, setting up claim processing with each new payer can also entail a potentially long involved testing/certification process.

This process can extend several weeks while sending test claims and live claims. Live claims may be rejected until all details unique to that payer are identified. Direct claim filing to each payer means this process needs to be established each time a new payer is added.

When a clearinghouse is used, LPHA staff submits claims to a single source. Submitting claims directly places an additional burden on billing staff to remember the specific requirements of each payer and to interpret each carrier's claim status reports. This is a very complicated and challenging process, simplified through the use of a clearinghouse.

When filing direct, additional software is often required. This software must be purchased and installed, resulting in additional costs. There is also a lack of effective claim management tools that are included with a clearinghouse relationship.

- **Selecting a Clearinghouse**

  When selecting a clearinghouse, consider the following:

  - Provide information on the PM system the LPHA is using and determine if the clearinghouse has experience working with this system. It is important the clearinghouse has experience working with the PM brand being used by the LPHA.
  - Contact the clearinghouse support staff prior to signing a contract. Customer service is crucial, so ensure the clearinghouse support staff is easily accessible, supportive, and able to meet LPHA needs.
  - Examine the clearinghouse error reports and control panel (the location on-line where claims are managed). Confirm they are both easy to access and understand.
  - Ensure the clearinghouse service offers month-to-month sign-up. If the clearinghouse is not meeting LPHA expectations, it is important to end the relationship quickly
  - If the LPHA is purchasing a Practice Management System and is obligated to use its clearinghouse, the LPHA should investigate the clearinghouse's reputation before making a final purchase decision on a PM system. PM systems often own or are affiliated with a clearinghouse. When an LPHA purchases the PM

system, the software vendor may expect the LPHA will automatically use that clearinghouse. This often provides a convenient solution, as long as the clearinghouse performs well and is reasonably priced.

7.22 Receiving Payments

- **Receiving Electronic Payments**

  Many third-party payers issue electronic payments and no longer issue paper checks. There are two parts to the electronic payment process. One involves the actual payment and the other involves transmission of an electric form of the Explanation Of Benefits form (EOB).

  Electronic funds transfer (EFT) is the electronic exchange or transfer of money from one account to another using a computer-based system. Use of EFT for paying insurance claims has improved cash flow for healthcare providers because deposits occur instantaneously.

  Medicare and claims filed direct to Iowa Medicaid require EFT of all payments. (Currently, Medicaid MCOs offer EFTs but do not require them.) Funds are deposited direct to the LPHA's bank account. LPHA staff will be required to complete the appropriate forms to establish the deposit.

  Along with the ability to have payments automatically deposited in the LPHA bank account, it is possible to receive electronic payment reports. These are referred to as 835 downloads. They are also called Electronic Remittance Advice (ERA). Recently, some payers have started using the term Electronic Payment statements (EPS) to describe their remittance reports. These reports are used to post payment information to patient accounts on the PM system. The electronic download may be received and viewed in two ways: 1) the 835 can be received as a download file from a payer or 2) it can be viewed and printed from a website. These services vary depending on options offered by the LPHA's clearinghouse. The clearinghouse will provide training on how to obtain 835s.

  If an independent clearinghouse is not being used, it is possible to obtain Medicare and Medicaid EFT's and downloads. There are two ways to receive the 835s from Medicare. One is through Medicare's clearinghouse, Electronic Data Interchange

Support Services (EDISS). All participating providers are required to sign up with EDISS to acquire 835 forms which can be downloaded at any time. The other way to obtain Medicare EOB's is accessing them through a Medicare link called C-snap. To retrieve the 835's, Medicare requires the use of Easy Print, a free, downloadable software program. All LPHA billing Medicare must sign up to receive EFT and 835 services. Sign-up cannot be done until credentialing has been completed.

Medicaid uses a similar process for electronic remittance. With the new Medicaid Managed Care program, electronic remittances must be established with each of the three Managed Care Organizations as well as with Iowa Medicaid Enterprise.

Several major insurance companies offer optional programs similar to the Medicare and Medicaid payment and remittance programs. However, it simplifies processes for the LPHA and most perceive EFTs as a beneficial enhancement of the billing process. Weekly verification of all anticipated EFT deposits to the LPHA bank account are a very important step in the process.

- **Receiving Remittance on Paper**

  By law, all insurance companies are required to offer the option of EFTs. Some make EFTs mandatory and others provide them as an optional service. If the LPHA decides not to sign up for EFT with commercial insurance companies, remittance checks and paper EOBs will be received in the mail.

  During the credentialing process, a "pay to" address will be established with each third-party payer. (Except Medicare and Medicaid, which require EFTs) The "pay to" address may be an office or Post Office Box. Any checks received should be stamped with a "Deposit Only" stamp upon receipt. Bank deposits should be made on a routine basis.

7.23 Posting Payments

Regardless of how payments are received, LPHA staff will be required to post payments into the patients' accounts. It is important to do this in a timely manner. If it's not done quickly, there is a likelihood that the Practice Management System will trigger unnecessary follow-up work or it could result in a statement being sent to the patient for claims already paid by insurance.

7.24 Patient Statements

Depending on the LPHA's policy, there will be a need to send billing statements to some patients. Insurance company contracts require an attempt be made to collect co-payments and co-insurance.

PM systems include modules to generate statements. With most PM systems, it is possible to print and mail statements in-house. However, a better option may be to outsource this responsibility.

Most clearinghouses offer patient statement processing that includes printing and mailing the LPHA's statements. Many companies are willing to compete for this business, so it is necessary to research options.

The LPHA's PM system automatically determines which patients are to receive a statement. After all insurances have been processed and paid, the remaining balance reverts to "patient pay responsibility".

The billing specialist has the option to write off the balance or submit it for a patient statement. Policies and procedures regarding patient statements should be created and included in the Billing Policies and Procedures Manual.

LPHA should consider sending one to three monthly patient statements. It is important to assess effectiveness of each statement to avoid wasting money on printing and postage.

7.25 Collection Agency

There are circumstances when an LPHA may choose to refer a patient to a collection agency. This is usually reserved for patients with high dollar balances from services such as travel immunizations or clinic visits. Oftentimes, these larger balances will result from patients with large deductible insurance plans, which are becoming very common.

Most collection agencies operate based on a percentage of the amount collected. Some charge a flat fee for each account submitted, regardless if the balance is collected.

It is advised that unpaid accounts not referred to a collection agency be written off the patient's account. In other words, the account should be adjusted to a zero balance. This means accounts receivable reports will reflect outstanding balances still having a likelihood of

collection. If old balances are allowed to remain, the total accounts receivable will be misleading and not representative of a collectible number.

7.26 Record Keeping

Medicare rules exist regarding retention of billing records. All billing records should be retained on file for seven years after the date of service on record. This is an industry standard. Include all documents used to generate claims:

- Superbill/Charge Ticket (Indicating all Codes)
- Insurance Card Copy
- Patient Registration/Demographic Form
- 835 or EOB
- Electronic Record of Claim Filed

These documents may be required for future audits by third-party payers. Also, the patient may require copies for legal actions or other purposes. There are a variety of reasons why it may be necessary to access patient billing records in the future.

With the advent of Electronic Health Records, scanning, and PM systems, most of today's medical documentation is stored electronically. However, records must be stored in a searchable format so it can be found and easily retrieved. PM system and EHR software vendors provide options for electronic document storage.

If budget is a consideration, legal requirements are met with storage of paper records. Typically, files are stored in batches by date of service. Charge information is retained in one set of files while payment information is kept in another file. The payment files are filed by the range of dates included on the EOB.

7.27 HIPAA Privacy

HIPAA is an acronym for the Health Insurance Portability and Accountability Act. It's a U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Department of Health and Human Services, these standards provide patients with access to their medical records and more control over how personal health information is used and disclosed. HIPAA represents a uniform, federal floor of privacy protections for consumers across the country.

State laws providing additional protections to consumers are not affected by this rule. HIPAA took effect in 2003.

Regarding billing, LPHA need to consider the following:

- All LPHA must maintain a HIPAA Privacy Manual with policies for privacy and security. This is required, whether or not they are billing third-party payers.
- All staff members must be trained annually on HIPAA rules and policies for privacy and security.
- All patients must be given the opportunity to read the LPHA's Notice of Privacy Practices. This document requires a patient signature and should be included in every patient's chart.
- Outside vendors purposely exposed to patient records or information of any kind must sign a HIPAA Business Associate Agreement.

It is assumed the LPHA is knowledgeable of HIPAA requirements.

Section 8: Outsourcing Credentialing and Billing

Rather than conducting an in-house billing program, some LPHA have chosen to outsource credentialing and billing. Medical billing companies vary greatly in their services. Some operate locally, others offer services statewide, and some are national or even international in scope. A lot of options are available for outsourcing, but finding the right medical billing company can be challenging. Billing companies are not accustomed to being employed by LPHA. Also, LPHA may not be considered attractive clients by some billing companies because of the limited volume they provide to a billing company. Most billing companies will charge a minimum monthly fee for clients with minimal volume. This minimum fee may be prohibitive for some LPHA to pay.

Finding the right billing company requires research. An Internet search for billing companies is an initial starting place. Also, visit the web site of the Healthcare Billing and Management Association (www.hbma.org) which lists several Iowa-based billing companies.

On a national basis, hundreds of medical billing companies are available. Also, a few billing software companies provide long distance billing services that can file claims and process payments.

8.1 Outsource Credentialing/Enrollment

Not all billing companies provide credentialing services. If they do, it is often a service separate from billing. Companies offering this service do so under a fee for service arrangement. The fee is charged, based on the extent of credentialing to be done.

For example, an LPHA that becomes a participating provider (PAR) with only Medicare, Medicaid, and Wellmark Blue Cross Blue Shield will have a fee less than if they are to be credentialed with all insurance companies in Iowa. In another example, the Medicare application is much more time consuming than the application for Midlands Choice, therefore the fee for Medicare will be more.

When outsourcing credentialing, LPHA staff will usually be required to complete an information form as a means of providing the credentialing company with information necessary to process applications. The LPHA will have to provide copies of all necessary support documents such as medical licenses, controlled substance licenses, medical school diploma, CLIA certificates, etc. If UHC, Coventry, Humana or InterPlan are among the desired insurance companies for credentialing, be sure to request the outsource

company to include CAQH set-up and ongoing updates in their cost estimate.

When the outsource company completes applications, original signatures are required. Some forms require signature by the medical director or other providers. Other documents will be signed by the LPHA administrator.

Outsourcing credentialing can reduce the workload for LPHA staff, but can be a cost prohibitive. Depending on the scope, costs to credential a singer provider for all insurances, including Medicare and Medicaid can range from $1,500 to $2,000. The fewer insurance companies credentialed, the lower the price.

If the LPHA plans to outsource credentialing, but do their own billing, it may be difficult to find someone to provide credentialing services. Often, because of limited staff resources, billing companies only provide credentialing for LPHA that have contracted to provide billing services too. If they do agree to do credentialing without billing, expect the cost to be increased.

8.2 Outsource Billing

When selecting a company to provide billing services, full disclosure of LPHA operations is essential. The billing company needs to understand exactly how the LPHA functions. Details about seasonality and the nature of services provided are essential for planning and budgeting. The billing company may not be familiar with the concept of a Medical Director issuing standing orders. Like all business relationships, the association with a billing company must be good for both parties to be successful.

Most billing companies welcome the opportunity to offer a presentation selling their services. Assess how they will handle all tasks in the billing process. At a minimum, this includes:

- Superbill development
- Charge entry and electronic claim filing
- Claim follow-up
- Filing secondary claims
- Handling telephone inquires
- Conducting follow-up activities
- Sending patient statements
- Working with a collection agency
- Providing informational reports

Learn as much as possible about staff working with the LPHA's account. Gauge the company and staff experience. Also, determine if solid back-up coverage is available for times when people are out of the office. Any delays in processing charges will negatively impact cash flow.

Determine how often electronic claims are filed. Some companies file daily while others file only once or twice a week. This can have a major impact on cash flow. Also, determine if they file direct to Medicare, Medicaid or Wellmark Blue Cross Blue Shield. Larger billing companies are likely to file direct with more third-party payers than a smaller company. This can positively impact speed of payments.

Also, determine how many patient statements are mailed to patients to collect outstanding balances. Determine how the outsource company handles this and if there are extra costs.

Most billing companies will require checks from insurance companies and patients to come directly to them. The checks will then be deposited into the LPHA's bank account. Of course, all EFT payments will transmit direct to the LPHA's bank account. The billing company staff will receive all electronic 835s and any paper EOBs for all payments. Also, some billing companies will pick up and deposit co-pays and other funds collected in the LPHA each day for deposit into the bank account, eliminating this task from LPHA Staff.

The billing company's willingness and ability to provide a wide range of reports on the LPHA's billing activity is also important. Reports should cover all information necessary for planning, budgeting, and tracking of clinic activities and results. Most reports are provided electronically. Some billing companies may charge a fee for printed reports. When outsourcing, price is always a consideration.

Medical billing companies price their services in a variety of ways. Many charge a percentage of payments posted against patient accounts. This includes all payments; even co-payments collected by LPHA staff. The billing company has to process those payments by posting them. This means of calculating the fee encourages billing companies to do everything possible to collect as much money as possible. The more money collected, the more the company makes.

The percentage charged is usually based on a sliding scale. When billing companies work for clients where the fee per patient visit is large, such as a surgeon's practice, the fee percentage will usually be fairly low. If the fee per claim is considerably less, like an LPHA, the

percentage will be higher so the billing company can generate revenue to cover its costs.

Some billing companies charge a flat fee per claim. This is a very straightforward way to determine cost for their services.

Interviewing several billing companies is recommended. It is the only way to effectively select the best company and best possible fee structure. The most helpful strategy when selecting a billing company is checking references. When the field has been narrowed, request a list of all clients, not just a few. Then, take the time to call the list of clients. Ask how the company performs on all tasks.

Billing companies will require a signed contract of agreement outlining details of the relationship. The agreement should spell out responsibilities of both parties. Typically, there is a clause for termination by either party. If the agreement is ended prematurely, there should be a clause requiring the billing company to continue pursing payment on all outstanding claims until both parties agree all funds have been collected. This may take anywhere from three to six months.

A medical billing company is a unique business partner. Successful billing requires integration into all of the LPHA's clinical activities assuring accurate coding and claim filing. If the billing company is not functioning as a trusted partner, there are great risks related to compliance and overall success of the billing process.

Section 9: Financial Analysis

Hopefully, most LPHA questions regarding the process of billing private insurance companies for HIV/STD/HCV services have been answered. But, there are still questions remaining in regard to the financial viability of a complex billing program.

As is the case with any business decision, it is important to assess both the risks and the possible rewards. But first, it's important to establish a primary goal. There are several possibilities to consider. Here are a few:

- Provide services to more constituents while breaking even on billing expenses.

- Provide services to more constituents while decreasing the cost per patient through billing, even if it's not a break-even proposition. This is sometimes described as "beneficial loss".

- Create a situation where revenues exceed billing expenses, allowing additional resources to invest in patient care programs.

- Begin a billing program now to be better prepared for changes that are likely in the near future.

There is no simple or definitive way to precisely determine an LPHA's financial success for launching or expanding a billing program. Many factors affect the success ratio.

If the LPHA plans to conduct an in-house billing program, it will be challenging to determine expenses. Putting exact numbers on costs for employees is very challenging because it is difficult to determine how much time will be required for the job. In many cases, the only way to get started will be by utilizing existing staff, at least in the beginning. Costs for computer hardware and software will be easier to determine. Vendors will be able to assist with these costs as well as expenses for clearinghouse services, etc. Also, when budgeting, be sure to allow a lot of staff time for research, program development, training, establishment of fee schedules, development of forms and procedures, etc. It's a large, time-consuming job, but it's doable.

Predicting revenue may be even more challenging. Determining what the revenue will be is difficult, if not impossible. It is necessary to know exactly how many patient claims will be billed and for what services. Also, it's necessary to know what health plans the patients

have for coverage. This is called the "payer mix". It is relevant because all payers pay at different levels. For example, in many cases, Wellmark Blue Cross Blue Shield will reimburse more than twice what is paid by Iowa Medicaid for the same services.

Insurance companies will not allow us to publish their fee scheduled. They are protected by copyright. Therefore, LPHA will need to depend on fee schedules provided by payers with their enrollment contracts. Fee schedules for Iowa Medicaid and Medicare are available on their respective websites. Medicaid's site includes a specific LPHA fee schedule that should be utilized, unless services are being provided by an ARNP. If that's the case, the general fee schedule for ARNP should be applied.

As mentioned previously, conducting a survey of current patients will help the LPHA determine the "payer mix". If it can determine what percentage of patients are covered by Medicaid or private insurances, this will help determine revenue potential. The LPHA should also factor in cash patients that may qualify for hardship benefits.

If the LPHA is planning to outsource the billing operation, the revenue estimation process will be easier. Most third-party billing companies charge a fee for up-front or start-up work. Once the LPHA signs on with a billing company, the company should be able to help with the expense and revenue estimates. Much less LPHA staff time will be required for start-up and ongoing implementation. Many of the expenses required for an in-house program will be absorbed by a single fee charged by the billing company.

If unsure of which way to proceed, it is recommended to explore both in-house and outsourcing for billing. The following comparison charts may be helpful with the revenue generation decision-making process.

Patient Pay vs. In-House Billing

Patient Pay	**Third-Party Billing**
<u>Pros</u>	**<u>Pros</u>**
Increased revenue ^	Increased revenue^
	No reductions in revenue due to making hardship adjustments.
No special implementation	
No new staff	
No cost for software	
Low operating cost	
No specialized training	
No privacy concerns	
<u>Cons</u>	**<u>Cons</u>**
	Complex implementation *
	Cost of additional staff *
	Cost of EHR software *
	Cost of PM software *
	Specialized training *
	Clearinghouse costs
	Possible privacy concerns
Requires a hardship police to help ensure all patients can receive services even if they don't have the means to pay.	
Reductions in revenue due to hardship policy adjustments	
A small number of patients may be reluctant to come to the LPHA if it asks for payment.	A small number of patients may be reluctant to come to the LPHA if it asks for payment.

^ ***Note***: *Revenue is hard to estimate, in large part due to the unknown percentage of patients with insurance coverage, possible patient privacy concerns and the impact of services that cannot be billed, i.e. grant and reimbursed counseling, tests, and treatments.*

* ***Note***: *All of these costs are eliminated or significantly reduced if the LPHA is already billing for immunizations and possibly for other services.*

A comparison of Patient Pay to In-House Third-Party Billing indicates that there are significant differences between the two options.

- Both options show increased revenue, however its unknown how much difference there may be.

- In-House Billing would not be subject to reductions in revenue due to hardship adjustments.
- Billing would be more complex and costly to implement.
- There may be privacy concerns with Billing
- Both still share the risk that a small number of patients may be reluctant to come to the LPHA.

One very important factor to remember is that when considering Third-Party billing, the LPHA must also implement Patient Pay. This is because the LPHA can't charge patients without insurance less than it's billing the insurance companies, themselves unless there is a hardship justification. The major benefit of this is that by implementing both options, all patients are accounted for. And the combination of revenue sources can have a meaningful impact on total additional revenue generated.

In-House Billing vs. Outsourced Billing

In-House Billing	**Outsourced Billing**
Pros	**Pros**
Increased revenue^	Increased revenue^
No reductions in revenue due to making hardship adjustments.	No reductions in revenue due to making hardship adjustments.
	Easier implementation
	Fewer additional staff
	No cost for PM software
	Less specialized training
	No clearinghouse costs
Cons	**Cons**
	Cost of identifying, evaluating and selecting a billing company.
	Cost of outsourced billing
Complex implementation *	
Cost of additional staff *	
Cost of EHR software *	Cost of EHR software *
Cost of PM software *	
Specialized training *	Some specialized training *
Clearinghouse costs	
Possible privacy concerns	Possible privacy concerns *
A small number of patients may be reluctant to come to the LPHA if it asks for payment.	A small number of patients may be reluctant to come to the LPHA if it asks for payment.

^ ***Note**: Revenue is hard to estimate, in large part due to the unknown percentage of patients with insurance coverage, possible patient privacy concerns and the impact of services that cannot be billed, i.e. grant and reimbursed counseling, tests, and treatments.*

* ***Note**: All of these costs are eliminated or significantly reduced if the LPHA is already billing for immunizations and possibly for other services.*

A comparison of in-House Third-Party Billing and Outsourced Third-Party Billing indicates meaningful differences between the two.

- Net revenue between the two options may be close to the same, however having them do the billing takes a lot of stress of the LPHA.
- Outsourced billing is easier to implement, but certain responsibilities may initially be more expensive.
- The total cost of engaging a billing company.
- No cost for PM software or clearinghouse services
- The cost of outsourcing is an unknown until the LPHA sits down with vendors and gets cost and net estimates.

Outsourcing has certain benefits, not the least of which is it takes much of the burden off the LPHA for implementation and operations of the billing process. The potential bar to being able to take advantage of this option is the total number of claims the LPHA would generate, and the monetary value of them. They are also likely to require a minimum monthly fee. The outsourcing company must be able to make money in order for the LPHA to make money.

Section 10: Conclusions

There are many factors to consider when deciding if this is the right time to initiate or expand the LPHA's third-party billing program to include HIV/STD/HCV services. It's a complex question that includes both financial considerations as well as philosophical issues. Hopefully, this manual has helped provide assistance with the financial side of the equation.

Section 11: Resources

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2. HIV/STD/HCV Related Code List
3. Job Description Samples
    a. Receptionist/Intake Specialist
    b. Patient Advocate
    c. Enrollment Specialist
    d. Billing Specialist
    e. Enrollment/Billing Specialist
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BILLING CODING GUIDE FOR HIV PREVENTION

PrEP, SCREENING, AND LINKAGE SERVICES

NASTAD

NASTAD is a member of the **CBA Provider Network** and has a long history of providing technical assistance and Capacity Building Assistance (CBA) to health departments to support HIV testing. This document is part of NASTAD's Sustainability and Innovation CBA resources. This and other resources are available for download at **www.NASTAD.org**.

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Health departments and other medical providers are billing Medicaid, Medicare and private insurers for services related to HIV prevention. The counseling services needed for the treatment and discussion of lab tests are intensive. While some of the services are provided in traditional healthcare settings and can be billed to public and private insurance, some of these services are provided in non-traditional settings by non-licensed professionals making it a challenge to bill insurance for these services. This guide describes the procedure and diagnosis codes that are accepted by public and private insurance, along with specific requirements for some Current Procedural Terminology (CPT®) billing codes. It also describes some of the challenges in obtaining reimbursement for testing, counseling, linkage to care and adherence services.

This document was developed by the National Alliance of State & Territorial AIDS Directors (NASTAD). NASTAD collaborated with Betsy Nicoletti, a billing and coding expert and this document's primary author, and the HIV Medicine Association, on research and development of this guide. This publication was supported, in part, by cooperative agreement number U65PS004390, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention and the Department of Health and Human Services.

DISCLAIMER

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Introduction

Health department HIV prevention programs and the medical providers they support offer a range of vital prevention services—including HIV Pre-exposure prophylaxis (PrEP) access services, linkage to care services, adherence counseling and HIV testing. Some of these services are performed by physicians, APRNs or PAs or the staff working under the supervision of these medical professionals. As an alternative, some of these same services are provided by community health workers (CHWs) or other non-licensed health professionals and peers.[1] Payment by insurance companies for these services can be problematic, depending upon whether the payer (e.g., Medicare, Medicaid or private insurance plans) recognizes the service, the credentials of the person proving the service, and the setting in which the service is provided. As a result of the Affordable Care Act (ACA), the percentage of uninsured patients has decreased (especially in states with Medicaid expansion). Medical practices and health departments are being encouraged to bill patients' insurance for reimbursement for these important services. This coding guide will describe procedure (CPT®) and diagnosis code (International Classification of Diseases, 10th revision, Clinical Modification, ICD-10) that health care professionals can use when submitting claims for reimbursement for these important services.

As a result of the ACA, the **percentage of uninsured patients has decreased**. Medical practices and health departments are being encouraged to bill patients' insurance for reimbursement for these important services.

CODING OVERVIEW AND OBSTACLES TO PAYMENT

Insurance companies pay for services that are described by a CPT® code and performed by a licensed practitioner or for work performed under the supervision of a licensed practitioner. Services are paid based on a fee associated with each CPT® code. In some instances, a set of services will be reimbursed at a "bundled" rate instead of based on fee-for-service. (A bundled payment covers multiple services, and may include services provided by two or more providers for a single episode of care.) The American Medical Association develops these CPT® codes to describe services performed by healthcare providers. 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.

[1] In 2013, the Centers for Medicare and Medicaid Services (CMS) amended federal preventive services Medicaid regulations to allow CHWs and other non-licensed providers to provide preventive services and have those services paid by state Medicaid programs when the services are *recommended* by a physician or other licensed provider. However, the state Medicaid program department must apply to CMS to be able to do this. CMS Center for Medicaid and CHIP Services Bulletin, Update on Preventive Services Initiatives, available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf; CMS Presentation "Medicaid Preventive Services Regulatory Change" Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, April 2014, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf.

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All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code in order to be reimbursed. A medical practice or 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.

In summary . . .

In summary, a group may only be paid by an insurance company or government payer for services, which are:

- Described by CPT® code,
- Performed by a licensed provider (credentialed for the provision of services by the payor) or under the supervision of the credentialed licensed provider, and
- Supported by an allowable ICD-10 diagnosis code.

THE GOAL OF THIS GUIDE

The goal of this coding guide is to describe scenarios for PrEP initiation and follow-up, adherence, linkage and other counseling services, and for lab tests for HIV and other STIs. It will discuss CPT® codes and ICD-10 diagnosis codes that could be reported as part of filing a claim with the patient's insurance company or government payer. It will also include a discussion of who may provide this service either directly or under the supervision of a licensed medical professional. Unfortunately, there are many services provided by HIV and other public health program staff members that are either not described by a CPT® code, or not performed by a healthcare professional who is credentialed by an insurance company or for which there is not a covered ICD-10 diagnosis code. This limits the ability to seek reimbursement from the insurer for the service.

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PrEP initiation and follow up in medical offices and clinics

Prior to receiving a prescription for PrEP, an individual needs counseling and lab testing. The Centers for Disease Control and Prevention (CDC) has published Clinical Guidelines for PrEP.[2] Lab tests must be ordered by a physician, advanced practice nurse or physician assistant. If the counseling is done by one of these professionals, this counseling can be billed in one of three ways:

1. Office/outpatient facility submits a claim for a new or established encounter with a billable provider (physician, APRN or PA) and all other services using appropriate CPT codes linked to the allowable ICD-10 diagnostic codes;

2. Office/outpatient facility submits a claim for a shared medical appointment provided by a billable provider and all services provided; or

3. Office/outpatient facility submits a claim for "Preventive health counseling" proved by a billable provider for patients who don't have an established diagnosed illness.

[2] CDC PrEP Clinical Guidelines, available at http://www.cdc.gov/hiv/pdf/prepguidelines.pdf

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MEDICAL OFFICE VISITS FOR PrEP INITIATION

Codes: Evaluation and Management (E/M) services

99201–99205 for "new" patients
99211–99215 for "established" patients.

Who can perform: Credentialed physicians, APRN, and PAs

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed provider?

Note: Insurance companies and state Medicaid programs develop their own rules about services performed by a staff member "incident" to a licensed clinician and supervised by the clinician. This guide addresses the Medicare rules and many state Medicaid programs and private insurance companies follow these rules.

A staff member who is not a physician, APRN, or PA may only report the lowest level established patient visit, 99211. This code, 99211, is commonly known as a "nurse" visit. For Medicare, or payers that follow Medicare rules, this must meet "incident to" guidelines.

How to use the E/M codes:

- Select the level of service based on the history, exam and medical decision making.
- If counseling dominates the visit, use time in minutes to select the code. Document the total face-to-face time of the service, the statement that more than 50% of the time was spent in discussion and the nature of the discussion (e.g., I spent 15 minutes in face-to-face with Mr. XXX discussing the risks, benefits, limitations, possible complications, dosing, importance of adherence, and required conditions for continued prescribing of PrEP. He voiced an understanding and wishes to proceed).

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SHARED MEDICAL VISITS

Codes: Use CPT® codes 99201–99205 for "new" patients, 99211–99215 for "established" patients

Who can perform: These codes (99201–99215) may only be reported by physicians, APRNs, and PAs.

Location: Office, clinic or outpatient department

Can a staff member perform the services under the supervision of a licensed provider?

No. These E/M codes cannot be used for that purpose. A staff member could participate in the shared medical appointment with the licensed clinician, but the physician, APRN, or PA would need to document the services in the patient's record.

How to use these codes for shared medical appointments:

Some medical groups use the office/outpatient codes to report a shared medical visit.

- Neither CMS nor CPT® has commented in their manuals on the use of office visit codes for this purpose.
- The American Association of Family Physicians (AAFP) has published a notification of a communication with CMS, allowing this.[3]
- The billing physician, APRN, or PA may see the patient in the presence of other group members, but must document in each patient's chart.
- Select the level of service based on the key components (history, exam and medical decision making) documented for each patient, not based on the time of the group.

NOTE: There is a code for group services, 99078. Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions). It has a status indicator of bundled, so it would not usually be paid. CMS assigns status indicators to CPT® codes. The most common are "active," "non-covered" and "bundled." An "active" code is paid by Medicare and most payers. A "non-covered" status indicator means that the service is not covered by the payer but may be billed to the patient. If a CPT® code has a status indicator of "bundled," it is not paid by the payer and typically cannot be billed to the patient.

[3] American Association of Family Physicians (AAFP), CMS Coding Notification, available at http://www.aafp.org/practice-management/payment/coding/group-visits.html

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PREVENTIVE MEDICINE CPT CODES

Prior to receiving a prescription for PrEP, a medical professional has a discussion with the patient and orders lab testing. As mentioned above, these discussions may be reported by billable health care professionals using individual office visit codes or with a shared medical appointment. However, an alternative is to bill for the counseling with "preventive medicine" codes. CPT® has a series of preventive medicine codes for risk factor reduction. The preventive medicine codes are intended to be used in the absence of an established diagnosis.

Codes:

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

Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure);

99411 approximately 30 minutes
99412 approximately 60 minutes

Who can perform: physicians, APRNs, or PAs

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed provider?

It would be prudent to ask payers if these counseling services could be performed by a staff member under the supervision of a physician, APRN, or PA.

How to use these codes:

- These time-based codes are used to document preventive counseling in patients without a diagnosis. Counseling for PrEP adherence in patients without HIV fits into this description.
- According to the CPT® book, "Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment."[4]
- The codes in the 99401–99404 series are for individual counseling and codes 99411 and 99412 are for group counseling.
- Document the time of the face-to-face counseling in the medical record, and describe the counseling.
- These codes have a status indicator of "non-covered" for Medicare, but some private payers recognize and will reimburse for them.

[4] 2016 Current Procedural Terminology, American Medical Association.

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Diagnosis coding

A list of relevant diagnosis codes is at the end of this guide. For the purposes of PrEP counseling, many groups use **ICD-10 Z20.2** "Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission." Two other commonly used codes are:

- **Z11.4** "Encounter for screening for human immunodeficiency virus [HIV])" and
- **Z11.3** "Encounter for screening for infections with a predominantly sexual mode of transmission."

LABS FOR PrEP INITIATION

The lab tests described below are ordered by a billable healthcare professional prior to PrEP initiation. They may also be ordered in other situations for HIV and STI screening.

Prior to starting PrEP, the billable healthcare professional orders screening laboratory tests. These include HIV serology, and screening for sexually transmitted infections. The medical provider may also order a metabolic panel and/or pregnancy test.

After starting PrEP medication, the medical provider will order surveillance lab tests every three-months. Although screening for HIV has an "A" rating from the USPSTF and is covered without a "patient due balance," insurers may not treat the tests provided every three months in the same way. The more frequently obtained HIV tests may be considered diagnostic, rather than screening, once treatment is initiated. As a result, patients may have a co-pay and/or deductible for these lab tests.

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Code	Description
86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)
	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)
	Infectious agent detection by nucleic acid (DNA or RNA)
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed
87536	HIV-1, quantification, includes reverse transcription when performed
87357	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique, includes reverse transcription when performed
87539	HIV-2, quantification, includes reverse transcription when performed
	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme- linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87390	HIV-1
87391	HIV-2
	For Medicare patients
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

Please see the discussion of modifiers after the HIV testing section of this guide.

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ICD-10 Code	Description	Use for
Z01.812	Encounter for preprocedural laboratory examination	Use for blood or urine tests prior to treatment.
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission	STI screening
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]	HIV screening
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
Z72.51	High risk heterosexual behavior	HIV, STI screening
Z72.52	High risk homosexual behavior	HIV, STI screening
Z72.53	High risk bisexual behavior	HIV, STI screening
Z72.89	Other problems related to lifestyle	Use for drug seeking behavior or unhealthy drinking behavior
Z79.899	Other long term (current) drug therapy	PrEP monitoring
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.
	Opioid abuse—no specific code for IV use	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.10	Opioid abuse, uncomplicated	
F11.90	Opioid use, uncomplicated	

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Adherence, linkage and other counseling services

PrEP ADHERENCE COUNSELING BY A PHYSICIAN, ADVANCE PRACTICE REGISTERED NURSE (APRN), PHYSICIAN ASSISTANT (PA)

Adherence counseling performed in a physician office may be billed with the same codes as listed in PrEP initiation, at the start of this guide, new and established patient E/M services (99201–99215) and preventive medicine counseling (99401–99412). With appropriate documentation, a physician, APRN, or PA could provide time-based counseling for a patient using office visit codes or preventive medicine counseling codes. See the section on PrEP initiation for a discussion of these services.

In addition, there is a code for high intensity behavioral counseling to prevent STIs, which can be billed in primary care settings, G0445. There are restrictions on G0445, described below.

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HIGH INTENSITY BEHAVIORAL COUNSELING TO PREVENT STIs

Code: G0445: Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to- face, includes education skills training & guidance on how to change sexual behavior, 20–30 minutes

Who can perform: The patient must be referred by a primary care provider to be eligible to receive this service, according to Medicare. Physicians, APRNs, and PAs may provide the service.

Location: A primary care setting.

Can a staff member perform the service under the supervision of a licensed provider?

It would be prudent to ask payers if these counseling services could be performed by a staff member under the supervision of a physician, APRN, or PA.

How to use this code:

- Use this code for individual face-to-face counseling, which includes education skills training and guidance on how to change sexual behavior.
- The service can be provided to individuals with multiple sex partners, those who are using barrier protection inconsistently, those were having sex under the influence of alcohol or drugs, those were having sex in exchange for money or drugs, age (24 years or younger and sexually active for women with chlamydia and gonorrhea), those who have had an STI within the past year, IV drug use (hepatitis B only), and for men those are having sex with men and engaged in high-risk sexual behavior.
- The patient must be referred for this service by a primary care provider and the service must be provided by a Medicare-eligible primary care provider in a primary care setting. For the purpose of this service, Medicare defines a primary care physician as someone who is a general practitioner, family practitioner, general internist, or an obstetrician or gynecologist, or a geriatric medicine physician or pediatric medicine physician or a clinical nurse specialist, a nurse practitioner, or physician assistant.
- A primary care setting is describe as one in which the provision of integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.[5]
- This would seem to require that the patient was referred by one of the primary care specialty physicians listed above, it could be provided in a health department or infectious disease practice the provided majority of the patient's care.
- These codes could be used for HIV negative or positive individuals.

[5] Department of Health and Human Services, CMS, MLN Matters MM7610

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CHRONIC CARE MANAGEMENT (CCM) SERVICES

As of this writing, one year after CMS allowed payment for chronic care management codes, provider billing for these services remains very limited. CMS allows for a physician, APRN, or PA to bill for services provided by staff members in coordinating care and providing non-face-to-face services to patients. However, the restrictions and difficulties of providing chronic care management are such that very few practices are attempting to do it. It is described below for the sake of completeness in this guide, but will probably be used infrequently.

Code: 99490: chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- Chronic conditions placed the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline,
- Comprehensive care plan established, implemented, revised, or monitored.

The problems must be of the type of conditions that pose a risk to the patient's health and well-being.

Who can perform:

Clinical staff under the supervision of a physician, APRN, or PA

Location: Office, clinic or outpatient department

How to use these codes:

- The practice must implement a care plan that addresses the patient's conditions and a clinical staff member must spend 20 minutes during a calendar month coordinating care and communicating with the patient.
- The practice must use a certified electronic health record.
- The physician, APRN, or PA develops a care plan, which is stored electronically. Everyone whose minutes "count" towards the 20 clinical staff minutes/month must have access to the care plan.
- Other key healthcare professionals must have electronic access to care plan: fax is insufficient as a means of communicating.
- A copy of the care plan is provided to the patient, electronically or on paper.
- The electronic record must include a full list of problems and medications and should facilitate caring for the patient during care transitions.
- Medication reconciliation is required as part of the service.
- The patient must have access to the practice 24 hours a day, seven days a week.
- One provider must be designated for continuity of care.

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Care management includes assessment of the patient's medical, functional and psychosocial needs manage care transitions, and coordinate with home and community services.

How to get started:

- The service must be implemented at a "comprehensive" E/M service (wellness visit or problem oriented service)
- Informed consent is required before starting the service. The practice must inform the patient that they will provide this service and get written consent from the patient to do so and to share information with other providers.
- The practice must also inform that patient that they can revoke this consent and stop receiving care management services at any time.
- Document these communications in the record, and give the patient a written or electronic copy of the care plan.

Supervision of clinical staff is general, not direct, supervision. That means the billing provider does not need to be in the suite of offices when the clinical staff provides the non-face-to-face care.

The practice may only report this service during the month in which the clinical staff has 20 minutes of non-face-to-face time with the patient.

Key points

- Work is done by clinical staff.
- May not count any clinical staff time on a day when the physician or qualified healthcare professional (APRN/PA) has an evaluation and management service with the patient.
- E/M services may be reported during the same calendar month the chronic care management is provided.

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SCREENING AND BEHAVIORAL COUNSELING IN A PRIMARY CARE SETTING TO REDUCE ALCOHOL MISUSE

The USPSTF recommends screening for alcohol misuse and behavioral interventions for individuals whose screening results are positive. CMS covers this service, but with limitations on which specialties can perform and be paid for the service. State Medicaid programs can individually decide whether or not to restrict coverage based on specialty designation of the provider.

Codes:

G0442 annual alcohol misuse screening, 15 minutes
G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Who can perform: Physicians, APRNs, or PAs

Location: Office, clinic, outpatient department or local or state health department

Screening can be performed in any location. Counseling is furnished by qualified physicians, advanced practice nurses and physician assistants in a primary care setting. These services may be provided to patients with or without HIV.

Can a staff member perform the service under the supervision of a licensed provider?

Medicare indicates that the counseling is performed furnished by "qualified primary care physicians or other primary care practitioners in a primary care setting."

How to use these codes:

Medicare states: For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443. Infectious Disease is not a specialty on CMS' list.

- 01-General Practice
- 08-Family Practice
- 11-Internal Medicine
- 16-Obstetrics/Gynecology
- 37-Pediatric Medicine
- 38-Geriatric Medicine
- 42-Certified Nurse Midwife
- 50-Nurse Practitioner
- 89-Certified Clinical Nurse Specialist
- 97-Physician Assistant

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For purposes of this covered service, the following Place of Service (POS) codes are applicable:

- 11 Physician's office
- 22 Outpatient hospital
- 49 Independent clinic
- 71 State or local public health clinic

The screening is covered annually by Medicare and up to four brief interventions are covered annually. State Medicaid programs and private payers may have their own rules and frequency limitations.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.

4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

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CARE COORDINATION, LINKAGE AND ADHERENCE SERVICES BY COMMUNITY HEALTH WORKERS (CHWs) AND OTHER NON-LICENSED/ PEER PROVIDERS IN NON-TRADITIONAL HEALTHCARE SETTINGS

As mentioned in the introduction of this guide, government healthcare payers and private insurance companies pay for services performed by licensed professionals in medical settings. This is an obstacle for payment for health departments and public health clinics that employ CWHs, peers, and other non-licensed staff for outreach and linkage services. On July 15, 2013, CMS changed a rule related to Medicaid coverage of preventive services in a non-traditional setting, provided by non-licensed staff members. This rule allows for state Medicaid programs to pay for preventive services provided by a non-licensed professional when the services are recommended by a physician, APRN, or PA. The definition of preventive services did not change. A CMS document describes these services as those that involve direct patient care and for the express purpose of diagnosing, treating or preventing illness or injury or other impairments to an individual's physical or mental health[6]

This allows CHWs or other non-licensed professionals to perform and bill Medicaid for services that would typically only be billed by physicians, advanced practice nurses or physician assistants. However, it requires that each individual state Medicaid program apply to CMS in order to be eligible to cover the services in this way. State health departments and public health clinics must query their own state Medicaid agency to determine if their state Medicaid has made this application to CMS.

If so, there are self-management education and training codes that can be billed by CHWs. Although coverage will vary by state Medicaid programs these will likely include self-management education and training. The CHWs must be supervised by a physician, APRN, or PA depending on the state.

Codes:

98960 Self management education and training face-to-face, 1 patient
98961 Self management education and training face-to-face, 2–4 patients
98962 Self management education and training, face-to-face, 5–8 patients

Location: Office, clinic or outpatient department

Can a staff member perform the service under the supervision of a licensed professional?

Check with your state Medicaid program and private insurers.

- In the Medicare fee schedule, these three codes have a status indicator of "bundled." That means that Medicare will not cover them, and many private insurers may not pay for these either. However, if a state Medicaid program has opted to expand their coverage of preventive services and received permission from CMS these codes could be used by CHWs or other non-licensed professionals.
- CPT® describes these services as performed by a physician, APRN, or PA, so check with your private insurers about CHWs or other non-licensed professionals performing them under the supervision of those licensed professionals.

[6] CMS Presentation "Medicaid Preventive Services Regulatory Change" Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, April 2014, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf.

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TARGETED CASE MANAGEMENT

In many cases, it is a CHW who is reaching out to individuals to encourage screening, to support the initiation of PrEP and to support the continued PrEP treatment. The work of CHWs is critical but too often, their work isn't recognized and paid by insurance companies. There are codes for this work described by the Healthcare Common Procedure Coding System (HCPCS). HCPCS codes are developed by CMS for its own use, but the codes are often also recognized by state Medicaid programs and commercial payers.

Codes:

T1017 Targeted case management, each 15 minutes

Although CMS developed this code, Medicare does not recognize it or set a fee for it. However, some state Medicaid programs do recognize and pay for the service performed by a CHW. For example, the state of Mississippi allows the service to be billed in the patient's home, in a school, in a community mental health center and in "other place of service not identified."[7] Texas allows targeted case management to be performed over the phone or face-to-face using these codes. The provider should append modifier IU when the service is performed face-to-face.[8] Florida Medicaid pays for targeted case management using these codes for group services.[9] Each state Medicaid program sets its own policies and payment amounts. Groups and organizations that are providing these services will need to check with their own state Medicaid program about coverage of this targeted case management.

Who can perform: This is a case management service, and may be performed by CHWs.

Location: Check with the state Medicaid program.

How to use these codes: Use these codes for case management services performed by CHWs. Document time in the medical record.

[7] Community/Private Mental Health Center Billing Guidelines, available at https://www.medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf.

[8] 2012 Texas Medicaid Provider Procedures Manual, Targeted Case Management, available at http://www.tmhp.com/HTMLmanuals/TMPPM/2012/Vol2_Children's_Services_Handbook.17.081.html.

[9] Florida Medicaid, Mental Health Targeted Case Management Handbook, available at http://www.flatherapy.com/therapy/wp-content/uploads/2010/05/CTCM-Handbook.pdf.

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MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

When a mental health assessment is performed by a physician, APRN, or PA, the clinician use E/M codes. Psychiatrists, social workers and psychologists use psychiatric diagnostic interview codes, in the Psychiatry section of the CPT® book when performing an initial evaluation. Some state Medicaid programs allow payment for a mental health assessment by non-licensed professionals, who are not listed above and not able to use the CPT® codes to report the evaluation.

Code: H0031: Mental health assessment, by non-physician

This code is not covered by Medicare, but may be covered by state Medicaid programs. Groups and organizations need to check with their individual state Medicaid programs. The service will typically be covered once per year. There may be diagnosis related restrictions related to the evaluation. It would be prudent to review if there are restrictions based on age, that is, if the service is only covered for children. One managed Medicaid program limits this to one assessment per year and does not require a prior authorization. This may require modifier "MO" indicating a master level provider has done the assessment.[10] Medicaid in the state of Georgia covers the service and has variable payment depending on the credentials of professional performing it.[11]

Who can perform:

Although this will vary by state, the code is applicable to trained para-professionals.

Location:

The service may be covered when done in a school, the patient's home or in some cases, in "other place of service."

How to use this code:

The provider must document a mental health assessment that includes the patient's past history, social, and family history. The assessment should include documentation of the patient's current functioning and an assessment of mental status. The history includes education, employment and any legal involvement as well as relationships and living environment. Document use of alcohol, tobacco and other drugs and behaviors that put the individual at risk.

[10] Magellan of Florida, Behavioral Health Therapy Services, available at https://www.magellancompletecareoffl.com/media/916790/appendix_k_combined.pdf.

[11] Georgia, Medicaid State Plan, Policy and Methods for Establishing Payment Rates for Other Types of Care for Services, available at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GA/GA-11-007-Att.pdf.

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Lab tests for HIV and other STIs

HIV SCREENING

Testing in the setting or PrEP initiation and adherence was discussed earlier in this guide, but the same CPT® codes are used for screening for HIV and other STI in other settings and situations.

Codes: HIV screening has an "A" rating from the USPSTF. It is a covered service by Medicare, Medicaid and commercial insurance companies. The USPSTF has not recommended specific screening intervals, but does describe recommendations for those intervals. That discussion is below.

PROCEDURE CODES

Code	Description
86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)
	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)
	Infectious agent detection by nucleic acid (DNA or RNA)
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed
87536	HIV-1, quantification, includes reverse transcription when performed
87357	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique, includes reverse transcription when performed
87539	HIV-2, quantification, includes reverse transcription when performed
	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme- linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87390	HIV-1
87391	HIV-2

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HCPCS code	Description
	Screening for Medicare patients
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

Modifiers are two-digit codes that are added to a procedure code when submitting a claim to an insurance company. These two digit modifiers do not change the definition of the code, but inform the payer of special circumstances related to the provision of the service.

There are three modifiers that could be used when screening for HIV.

- Use of modifier 33: In response to the ACA, CPT® developed a modifier to be used when a service is provided that is a service that carries an "A" or "B" rating from the USPSTF (and is thus required to be provided without patient cost sharing). Modifier 33 **Services:** When the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF "A" or "B" rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.[12] It is correct coding to append modifier 33 to any service that meets this description.

Use modifier 33 on the CPT code for HIV screening. This informs the payer that the service is a service recommended by the USPSTF. For patients with commercial policies, it insures that the insurance company will pay the claim without a patient due amount. No co-pay or deductible should be applied to a service with a USPSTF "A" or "B" rating.

- 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). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

Use this modifier on the HCPCS codes for Medicare patients, G0432, G0433, G0435.

Modifier QW CLIA waived test

- CLIA waived tests on this list are 86701, G0433, G0434 87389

[12] Current Procedural Terminology 2016, American Medical Association

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DIAGNOSIS CODES

ICD-10 Code	Description	Use For
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]	HIV screening
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
Z72.51	High risk heterosexual behavior	HIV, STI screening
Z72.52	High risk homosexual behavior	HIV, STI screening
Z72.53	High risk bisexual behavior	HIV, STI screening

- The USPSTF recommends that all pregnant women be screened, and any woman who presents while in labor whose HIV status is unknown. It also recommends screening in individuals who are age 15–65, and states that younger and older individuals who are increased risk should be screened.
- Medicare allows for annual screening of all individuals who are at increased risk, including anyone who asks for the test and pregnant women. For pregnant women, Medicare covers the test three times per pregnancy. While all commercial carriers will cover the test, because the USPSTF does not give a frequency recommendation, commercial carriers and state Medicaid programs are free to develop their own guidelines. For example, Aetna simply quotes the USPSTF and does not specifically state what their frequency limitations are. It notes that the CDC recommends that high risk individuals be screening annually.[13]

UnitedHealthcare, in its National Coverage Determination N210.7 gives these frequency limits states that except for pregnant beneficiaries, it covers one annual screening. UnitedHealthcare's preventive medicine policy for screening for non-Medicare replacement plans lists the lab service as covered, but does not describe frequency. It can be assumed that it will have similar frequency limitations.

Complications

A screening test may be denied because:

- 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.

[13] Aetna, HIV Testing Policy, available at http://www.aetna.com/cpb/medical/data/500_599/0542.html

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HIV SCREENING IN A NON-PRIMARY CARE SETTING

An insurance company is required to cover any service given an "A" or "B" grade from the USPTSF. This includes HIV screening. (See the appendix for a table that lists related services with an A or B rating.) Emergency departments, conducting routine HIV screening of patients, have reported payment challenges. Details on the USPSTF HIV screening recommendations are available online.[14]

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.[15]
- Modifier 33 was not appended to the CPT® or HCPCS code.

[14] See U.S. Preventive Services Task Force. H. *Human Immunodeficiency Virus (HIV) Infection: Screening.* Release Date: April 2013, available at: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening.

[15] From the USPSTF regarding screening intervals: "The evidence is insufficient to determine optimum time intervals for HIV screening. One reasonable approach would be one-time screening of adolescent and adult patients to identify persons who are already HIV-positive, with repeated screening of those who are known to be at risk for HIV infection, those who are actively engaged in risky behaviors, and those who live or receive medical care in a high-prevalence setting. According to the CDC, a high-prevalence setting is a geographic location or community with an HIV seroprevalence of at least 1%. These settings include sexually transmitted disease (STD) clinics, correctional facilities, homeless shelters, tuberculosis clinics, clinics serving men who have sex with men, and adolescent health clinics with a high prevalence of STDs. Patient populations that would more likely benefit from more frequent testing include those who are known to be at higher risk for HIV infection, those who are actively engaged in risky behaviors, and those who live in a high-prevalence setting. Given the paucity of available evidence for specific screening intervals, a reasonable approach may be to rescreen groups at very high risk (see Assessment of Risk) for new HIV infection at least annually and individuals at increased risk at somewhat longer intervals (for example, 3 to 5 years). Routine rescreening may not be necessary for individuals who have not been at increased risk since they were found to be HIV-negative. Women screened during a previous pregnancy should be rescreened in subsequent pregnancies."

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Screening for syphilis

One annual screening for syphilis in men or women at increased risk. For pregnant women, one screening per pregnancy; two additional screenings in the third trimester and at delivery if at increased risk for STIs.

CPT® Code	Description
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-troponemal antibody; quantitative
86780	Treponema pallidum

Screening for gonorrhea

One annual screening for gonorrhea in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy who are at increased risk and who continue at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for gonorrhea in men, and this will affect payer policies. The ACA mandated that health insurers cover screening services that the USPSTF gives an A or B rating.

CPT® Code	Description
87590	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA) Neisseria gonorrhoeae, quantification

Screening for hepatitis B

The USPSTF recommends screening for individuals at risk. Frequency is not described. For pregnant women, screening is recommended at the first visit. Medicare recommends and covers an additional screening at delivery if the individual is still at increased risk for STIs.

CPT® Code	Description
Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method;	
87340	hepatitis B surface antigen (HBsAg)
87341	hepatitis B surface antigen (HBsAg) neutralization

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Screening for chlamydia

One annual screening for chlamydia in women who are not at increased risk. For pregnant women, up to two screenings per pregnancy who are at increased risk and who continue to be at risk for the second screening. The USPSTF does not have sufficient information to recommend screening for chlamydia in men.

CPT® Code	Description
86631	Antibody Chlamydia
86632	Antibody Chlamydia, IgM
87110	Culture, chlamydia, any source
87270	Infectious agent antigen detection by immunofluorescent technique chlamydia trachomatis
87320	Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay {EIA}, enzyme–linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method, chlamydia trachomatis
87490	Infectious disease agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, direct probe technique
87491	Infectious diseases agent detection by nucleic acid (DNA or RNA) Chlamydia trachomatis, amplified probe technique
87810	Infectious agent antigen detection by immunoassay with direct optical observation chlamydia trachomatis

Other codes

CPT® Code	Description
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

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Appendix

COMMON DIAGNOSIS CODES

ICD-10 code	Description	Use for
Z01.812	Encounter for pre-procedural laboratory examination	Use for blood or urine tests prior to treatment.
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission	STI screening
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]	HIV screening
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
Z72.51	High risk heterosexual behavior	HIV, STI screening
Z72.52	High risk homosexual behavior	HIV, STI screening
Z72.53	High risk bisexual behavior	HIV, STI screening
	Opioid abuse—no specific code for IV use	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.10	Opioid abuse, uncomplicated	
F11.90	Opioid use, uncomplicated	
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.
Z72.89	Other problems related to lifestyle	Use for drug seeking behavior or unhealthy drinking behavior
Z79.899	Other long term (current) drug therapy	PrEP monitoring
Z86.59	Personal history of other mental and behavioral disorders	History of drug use. For opioid dependence in remission, use code from F11.
Z87.898	Personal history of other specified conditions	Use for a history of drug use, non-dependent, in remission.

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PREGNANCY RELATED DIAGNOSIS CODES

ICD-10 code	Description
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z32.00	Encounter for pregnancy test result unknown
Z32.01	Encounter for pregnancy test result positive
Z32.02	Encounter for pregnancy test result negative

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CPT® CODES

CPT® Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
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.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

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CPT® CODES (continued)

CPT® Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	approximately 35 minutes
99403	approximately 45 minutes
99404	approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	approximately 60 minutes
98960	Self management education and training face-to-face, 1 patient
98961	Self management education and training face-to-face, 2-4 patients
98962	Self management education and training face-to-face, 5-8 patients
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to- face, includes education skills training & guidance on how to change sexual behavior, 20-30 minutes
HCPCS code	**Description**
T1017	Targeted case management, each 15 minutes
H0031	Mental health assessment, by non-physician
CPT® Code	**Description**
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
80053	Comprehensive metabolic panel
82565	Creatinine; blood
82570	Creatinine other source (urine)
82575	Creatinine clearance

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UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDATIONS

Population	Recommendation	Grade
	HIV SCREENING	
Adolescents and Adults 15–65 Years Old	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. Go to the Clinical Considerations for more information about screening intervals.	A
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
	ALCOHOL MISUSE SCREENING	
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I
	CHLAYMIDIA AND GONORRHEA	
Sexually Active Women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B
Sexually Active Women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B
Sexually Active Men	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.	I
	HEP B IN PREGNANT WOMEN	
Pregnant Women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A
	HEP B AT HIGH RISK FOR INFECTION	
Persons at High Risk for Infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection.	B
	HEP C	
Adults at High Risk	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering 1-time screening for HCV infection to adults born between 1945 and 1965.	B
	HIV	
Adolescents and Adults 15–65 Years Old	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened. Go to the Clinical Considerations for more information about screening intervals.	A

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UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDATIONS (continued)

Population	Recommendation	Grade
	HIV	
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A
	SYPHILIS IN PREGNANCY	
Pregnant Women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A
	SYPHILIS SCREENING	
Persons at Increased Risk	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A
Pregnant Women	The USPSTF strongly recommends that clinicians screen all pregnant women for syphilis infection.	A
Asymptomatic Persons, Not at Increased Risk	The USPSTF recommends against routine screening of asymptomatic persons who are not at increased risk for syphilis infection	D
	COUNSELING-ALCOHOL	
Adults aged 18 and older	The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I
	COUNSELING-BEHAVIORAL	
Sexually Active Adolescents and Adults	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).	B

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Glossary

AMA	American Medical Association
APRN	Advance Practice Registered Nurse
CCM	Chronic Care Management
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CHW	Community Health Workers
E/M	Evaluation and Management
HCPCS	Healthcare Common Procedure Coding System
HIV	human immunodeficiency virus
ICD-10-CM	International Classification of Diseases, 10th revision, Clinical Modifications
NASTAD	National Alliance of State & Territorial AIDS Directors
PA	Physician Assistant
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
USPSTF	United States Preventive Services Task Force

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Murray C. Penner, Executive Director

Andrew Gans, New Mexico, Chair

April 2016

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NASTAD

HIV/STD/HCV Billable Code Possibilities

Note:

The following list is a compillation of HIV/STD/HCV related CPT and HCPCS codes from various sources.

The ability to bill these codes depends on the specific requirements for each individual code, and the delivery of the code by a properly licensed and enrolled provider. Not all providers can deliver and bill each code.

Codes marked with an asterisk (*) are duplicates of codes noted earlier in this list

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Immunization Administrations, Etc.		
Single Injection, first component ^	90460	
Each Additional component, same injection ^	90461	
Single injection: single or combo vaccine	90471	
Each Additional Injection, same encounter	90472	
IM Adm Transl/Oral 1 Vac (Single or Combo)	90473	
IM Adm Intransl/Oral Each Additional	90474	
Collection: venous blood - venipuncture	36415	
Collection: Capillary (finger, heel, ear stick)	36416	
Specimen Handling: office to lab	99000	
Smear Gram Stain	87205	
Smear wet mount	87210	
Tissue Exam for Fungi	87220	
Virus Innoculation Tissue Cult (S Herpes)	87252	
IAADI not otherwise spec, each organism	87299	
Cytopath C/V Thin Layer	88142	
Medication admin: oral, IM and/or subcut	T1502	
Office/other outpatient E/M established patient	99211	
UA - Unine Analysis	81000	
UA Nonauto w/o Scope (dipstick)	81002	
UA Auto w/o Scope (dipstick)	81003	
Therapeutic Prophylactic/DX Injection Subq/IM	96372	
Chronic Care Mgmt Svcs, at least 20min	99490	
Targeted Case Management, each 15 min	T1017	
High Inten Beh Counseling, semi-annual, 30 min	G0445	
Sign Lang/Oral Interpreter, per 15min	T1013	
Med Serv Eve/Wkend/Holiday	99051	
^ It is recommended that these codes		
should not be provided by an RN.		
See code requirements.		

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Chlamydia Screening		
Antibody; Chlamydia	86631	
Antibody,Chlamydia, IgM	86632	
Culture, Chlamydia, any source	87110	
IAAD Chlamydia Trachomatis AG IF	87270	
IAAD IA Chlamydia Trachomatis	87320	
IDNA Chlamydia Trach Dir Probe TQ	87490	
IDNA Chlamydia Trachomatis Amp Probe TQ	87491	
IDNA Chlamydia Trachomatis Quant	87492	
IADNA Multiple Organisms Dir Probe TQ	87800	
IADNA Multiple Organisms Amp Probe TQ *	87801	
Chylmd Trach Assay w/Optic	87810	
Gonorrhea Screening (Neisseria)		
Neisseria Gonorrhea direct probe tech.	87590	
Neisseria Gonorrhea ampllified probe	87591	
Neisseria Gonorrhea DNA quantification	87592	
DNA/RNA direct probe technique *	87801	
Culture, presumptive, path Org, screening	87081	
N. Gonorrhoeae Assay w/Optic	87850	
Syphillis Screening		
Syphillis Test Non-Trep Qual	86592	
Syphillis Test Non-Trep Quant	86593	
Antibody; Treponema pallidum	86780	
Dark Field Examination	87164	
Trichomoniasis Testing		
IDNA Trich Vaginalis direct probe Tech	87660	
IDNA NOS amplified probe, ea. Organism	87798	
IDNA Trich Vaginalis Amplifed Probe Tech	87661	
Bacterial Vaginosis Testing		
Smear wet mount *	87210	
Herpes Testing		
Virus Innoculation Tissue Cult (S Herpes) *	87252	
Antibody: Herpes Simplex, T1	86695	
Antibody: Herpes Simplex, T2	86696	

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Human Papilloma Virus DNA Testing		
HPV detection by DNA or RNA, Dir Probe	87620	
HPV detection, DNA or RNA, Amp Probe	87621	
HPV Quantifiction	87622	
IDNA HPV Low-Risk Types	87623	
IDNA HPV High-Risk Types	87624	
IDNA HPV Types 16 & 18 Only	87625	
Human Papillona Virus Vaccinations		
Gardasil®, HPV4, 3 dose sched (req NDC#)	90649	
Cervarix®, HPV2, 3 dose sched (req NDC#)	90650	
Gardasil 9, HPV9, 3 dose sched (req NDC#)	90651	
Non-Gonoccal Testing		
Smear Gram Stain *	87205	
HIV Screening		
HIV-1	86701	
HIV-2 antibody	86702	
HIV or HTLV antibody, confirmatory	86689	
HIV-1&2 antibody, single result	86703	
IDNA HIV-1, direct probe TQ	87534	
IDNA HIV-1, amp probe & rev transcription	87535	
IDNA-HIV-1, quant & reverse transcription	87536	
HIV-2, direct probe technique	87537	
HIV-2, amp probe & reverse transcription	87538	
HIV-1 AG W/HIV-1 & HIV-2 AB	87389	
HIV-1 AG IA	87390	
HIV-2 AG IA	87391	
Phenotpe Prediction Infectious Agent Drug	87900	
Genotype DNA HIV Reverse Trans&Proto	87901	
Phenotype DNA HIV w/Culture	87903	
Phenotype DNA HIV w/Culture ADD	87904	
Genotype DNA/RNA HIV	87906	
Trofile Co-Receptor Tropism Assay	87999	
T Cell Absolute Count/Ration	86360	
EIA HIV-1/HIV-2 screen	G0432	
ELISA HIV-1/HIV-2 screen	G0433	
Oral HIV-1/HIV-2 screen, rapid antibody	G0435	
HIV-1 antibody testing of oral transudate	S3645	

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Hepatitus A Testing		
Hep A Antibody	86708	
Hep A IGM Antibody	86709	
Hepatitis A Immunization		
Hep A Adult - Each	90632	
Hep A Peds	90633	
Hep A Peds, 3 dose sched	90634	
Hep A/B (Twinrix) - Each *	90636	
Hepatitus B Testing		
IAAD IA Hep B Surf Antigen	87340	
IAAD Hep B Surf Antigen, neutralization	87341	
Hep B core antibody (HBcAb); IgM antibody	86705	
Hep B Surf AB (HBsAB)	86706	
Hep B Core antibody (HBcAB), total	86704	
Hep B Genotype DNA	87912	
Hepatitis B Immunization		
Hep A/B (Twinrix) - Each *	90636	
Hep B Vaccine Adult, 2 Dose IM	90739	
Hep B Vaccine Dialysis Dosage, 3 Dose IM	90740	
Hep B Vaccine Adolescent, 2 Dose IM	90743	
Hep B - Peds, 3 dose schedule	90744	
Hep B - Adult, 3 dose schedule	90746	
Hep B Vaccine Dialysis Dosage, 4 Dose IM	90747	
Administration of Hep B vaccine	G0010	
Hepatitus C Testing		
Hep C Antibody	86803	
Hep C RNA Dir Probe	87520	
Hep C Antibody Amplified Probe Technique (DNA/RNA)	87521	
Hep C IDNA Quant&Reverse Transcrption	87522	
Hep C, Rapid (DNA/RNA)	87902	
Hep C Antibody Confirmatory Tes	86804	
Hep C Screen High Risk/Other	G0472	
Pregancy Test		
UHGG - Urin Pregancy	81025	

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Tuberculosis (TB)		
TB - Quantiferon Gold	86480	
TB - Skin test, Tuberculosis, intradermal	86580	
Medications		
Ceftriaxone sodium-Inj, 250 mg	J0696	
Bicillin - Injection, 100,000 unit	J0561	
Zithromax - Per 500mg	J0456	
Medroxyprogesterone Acetate 1mg	J1050	
(Depo-Provera)	-	
New Patient Problem Visit		
For PrEP Initiation (Pre-Exp Prophylaxis)		
Office/Outpatient Visit New 10 min	99201	
Office/Outpatient Visit New 20 min	99202	
Office/Outpatient Visit New 30 min	99203	
Office/Outpatient Visit New 45 mim	99204	
Office/Outpatient Visit New 60 min	99205	
Established Patient Problem Visit		
Office/Outpatient Visit Estab 5 min	99211	
Office/Outpatient Visit Estab 10 min	99212	
Office/Outpatient Visit Estab 15 min	99213	
Office/Outpatient Visit Estab 25 min	99214	
Office/Outpatient Visit Estab 40 min	99215	
Periodic Preventive Medicine New Patient		
INIT PM E/M New Patient < 1 Year	99381	
INIT PM E/M New Patient 1-4 Years	99382	
INIT PM E/M New Patient 5-11 Years	99383	
INIT PM E/M New Patient 12-17 Years	99384	
INIT PM E/M New Patient 18-39 Years	99385	
INIT PM E/M New Patient 40-64 Years	99386	
INIT PM E/M New Patient 65+ Years	99387	
INIT Prev Phys Ex, FtoF first 12 mo Mcare	G0402	

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Periodic Preventive Med Established Patient		
Periodic PM Reeval Est Patient <1 Year	99391	
Periodic PM Reeval Est Patient 1-4 Years	99392	
Periodic PM Reeval Est Patient 5-11 Years	99393	
Periodic PM Reeval Est Patient 12-17 Years	99394	
Periodic PM Reeval Est Patient 18-39 Years	99395	
Periodic PM Reeval Est Patient 40-64 Years	99396	
Periodic PM Reeval Est Patient 65+ Years	99397	
Annual Well Visit, Incl PPS Init Visit	G0438	
Annual Well Visit, Incl PPS Sub Visit	G0439	
Annual Gyno Exam, new patient	50610	
Annual Gyno Exam, established patiient	50612	
Annual Gyno Ex, Clinical Breast w/o pelvic	50613	
Preventative Medicine Counseling, Individual		
Preventative Counseling Indi 15 min	99401	
Preventative Counseling Indi 30 min	99402	
Preventative Counseling Indi 45 min	99403	
Preventative Counseling Indi 60 min	99404	
Preventative Medicine Counseling, Group		
Preventative Counseling Gro 30 min	99411	
Preventative Counseling Gro 60 min	99412	
Self Management Edu and Training, FtoF		
Self-Mgmt Education & Train 1 PT	98960	
Self-Mgmt Education & Train 2-4 PT	98961	
Self-Mgmt Education & Train 5-8 PT	98962	
Mental Health Assessment by Non-Physician		
MH health assess by non-md	H0031	
Alcohol		
Annual Alcohol screen 15 min	G0442	
Brief alcohol misuse counsel 15 min	G0443	
Alcohol and/or Substance Abuse		
Alcohol/Subst Screen& Interven, 15-30min	99408	
Alcohol/Subst Screen& Interven, >30min	99409	

HIV/STD/HCV Related Code List		***CPT And HCPCS Codes***	***Notes***
Tobacco Use			
Tobacco Use Counsel	3-10min	G0436	
Tobacco Use Counsel	>10min	G0437	
Wart Removal			
Vulva: simple		56501	
Vulva: extensive		56515	
Vagina: Simple		57061	
Vagina: extensive		57065	
Anal: simple		48900	
Anal: extensive		46924	
Penis: simple (cryo)		54056	
Penis: extensive		54065	
Lesions, Benign; Destruction (not skin tags)			
Destruct B9 Lesion: 1-14		17110	
Destruct B9 Lesion: 15+		17111	
Lesions, Destruction of: Anus			
Destruction Anal Lesions. Simple		46900	
Destruction Anal Lesions. Extensive		46924	
Lesions, Destruction of: Penis			
Destruction Penis Lesions. Simple		54050	
Destruction Penis Lesions. Extensive		54065	
Lesions, Destruction of: Vulva			
Destroy Vulva Lesions. Simple		56501	
Destroy Vulva Lesions. Extensive		56515	
Lesions, Destruction of: Vaginal			
Destroy Vaginal Lesions. Simple		57061	
Destroy Vaginal Lesions. Extensive		57065	
Coloscopy			
BX/Curett of Cervix w/Scope		57454	

HIV/STD/HCV Related Code List	***CPT And HCPCS Codes***	***Notes***
Other		
Gonadotropin,chorionic (hCG) quant	84702	
Gonadotropin, chorionic (hCG) Qual	84703	
Comprehensive metaboic panel	80053	
Creatinine, blood	82565	
Creatinine, other source (urin)	82570	
Creatinine clearance	82575	
Notes		

Job Description

(Name of LPHA)

Receptionist

Reports To: *(_____)* **Department***: (_____) (Full Time /Part Time / Exempt / Temp)*

Major Responsibilities

This position is responsible for greeting visitors and patients; determining the reason for the visit; securing patient information and signatures on required documents; and establishing methods of payment for services. This person also asks, receives and accounts for payments, and handles incoming calls and other office duties as directed.

Scope and Impact

The receptionist contributes to the first impressions visitors and patients have of the LPHA. By properly handling the registration procedure, this person also sets the stage for a smoothly executed patient experience. Information gathered during intake satisfies certain regulatory and legal requirements and contributes to the efficient scheduling of appointments with medical staff. In the course of business, this person interacts directly with patients, visitors, management and medical staff. The position also has a contributory effect on meeting budget goals which can impact both delivery of essential healthcare services and achieving the LPHA's mission.

Primary Job Functions *(±90%) - If needed, additional functions and responsibilities may be required.*

- Greets visitors and patients in a friendly, competent, professional and informed manner.
- Determines reason for the visit, gathers patient information and secures signed documents as needed.
- Schedules patient appointments.
- Eases any concerns or distress patients may exhibit during the intake process.
- Responds to questions with timely, accurate and complete information.
- Determines the patient's method of payment and secures insurance information as needed.
- Asks, receives and accounts for payments.
- Applies the LPHA's Hardship Policy as appropriate.
- Answers and redirects incoming calls as appropriate.
- Complies with all HIPAA, and other regulations and requirements.

Special Requirements, Skills, Abilities and Qualities

- Requires a self-starter with the ability to work both independently and as an team member.
- Good natured with a positive attitude and a smile; able to perform under pressure.
- Ability to interact effectively and in a supportive manner with patients.
- Finds helping people who need the LPHA's services rewarding and fulfilling.
- Always courteous and respectful regardless of race, creed, family and/or economic situation.
- Bilingual language skills a plus.
- Effective oral and written communication skills, including phone skills and etiquette.
- Attention to detail, and adherence to established policies and procedures required.
- A problem solver, with the ability to organize and prioritize responsibilities.
- Is flexible, and able to embrace and implement change.
- Has the willingness and ability to request payment for services.
- Knowledge of medical terminology a plus.
- Minimum of high school diploma or equivalent.
- Understands and can do basic math without a calculator. Can balance his or her own checkbook.
- Touch typing/keyboarding and touch10-key; both with speed and accuracy.
- Working knowledge of Windows personal computer, Microsoft Word and Excel.
- Prior reception experience a plus; especially in a healthcare setting.

Please note that a financial and legal background check will be required. Must pass county physical examination, which includes a drug test after offer of employment.

Job Description

(Name of LPHA)

Patient Advocate

Reports To: *(_____)* **Department***: (_____)* *(Full Time/Part Time/Exempt/Temp)*

Major Responsibilities

This position is responsible for extending the LPHA's patient-focused, positive medical experience; making an initial determination of a patient's needs; securing information and signatures on required documents; providing information and answering questions; determining ability to pay; solving payment challenges; verifying insurance coverage and authorizations; transitions the patient to the clinic workflow; and asking for, receiving and accounting for payments.

Scope and Impact

The patient advocate is an interim step between check-in and medical treatment, contributing to the image of the LPHA, and the execution of an efficient, satisfying patient experience. Information gathered satisfies certain regulatory and legal requirements, and contributes to the efficient scheduling of appointments. In the course of business, this position interacts directly with patients, visitors, management and medical staff. The position also has a contributory effect on meeting budget goals which can impact both delivery of essential healthcare services and achieving the LPHA's mission.

Primary Job Functions *(If needed, additional functions and responsibilities may be required.)*

- Greets patients in a friendly, competent, professional and informed manner.
- Determines reason for the visit, gathers patient information and secures signed documents as needed.
- Provides information, answers questions, and eases any concerns or distress patients may exhibit.
- Determines patient's ability to pay, method of payment, and applies Hardship Policy as appropriate.
- Secures insurance information, verifies patient's coverage and obtains prior authorizations.
- Enters patient information into patient's records.
- Interacts with medical staff, and enters patient into medical workflow.
- Reviews charges with patient, then asks for, receives and accounts for payments.
- Coordinates follow-up appointments and expedited partner treatment EPT.
- Complies with all HIPAA, and other regulations and requirements.

Special Requirements, Skills, Abilities and Qualities

- Requires a self-starter with the ability to work both independently and as an team member.
- Good natured with a positive attitude and a smile; able to perform under pressure.
- Ability to interact effectively and in a supportive manner with patients.
- Finds helping people who need the LPHA's services rewarding and fulfilling.
- Always courteous and respectful regardless of race, creed, family and/or economic situation.
- Knowledge of medical terminology, clinical procedures, medical coding, third-party billing a plus.
- Effective oral and written communication skills, including phone skills and etiquette.
- Attention to detail, and adherence to established policies and procedures required.
- A problem solver, with the ability to organize and prioritize responsibilities.
- Is flexible, and able to embrace and implement change.
- Has the willingness and ability to request payment for services.
- Minimum of high school diploma or equivalent. Bilingual language skills a plus.
- Knowledge of office terminology, procedures and office equipment required.
- Prior customer service and financial experience a plus; especially in a healthcare setting.
- Touch typing/keyboarding (55 wpm) and touch10-key; both with speed and accuracy.
- Understands and can do basic math without a calculator.
- Working knowledge of Windows personal computer, Microsoft Word and Excel.

Please note that a financial and legal background check will be required. Must pass county physical examination, which includes a drug test after offer of employment.

Job Description

(Name of LPHA)

Enrollment Specialist

Reports To: *(_____)* **Department**: *(_____) (Full Time/Part Time/Exempt, Temp)*

Major Responsibilities

The Enrollment Specialist is responsible for credentialing, re-credentialing and contracting healthcare facilities and providers with Medicare, Medicaid and other health insurance plans.

Scope and Impact

The enrollment specialist is a direct link between the LPHA and medical insurance plans, and interacts directly with LPHA management, providers, and insurance plan representatives. The complete, accurate and timely execution of the specialist's enrollment responsibilities directly affects the ability of the LPHA to deliver billable services which generate significant revenue. This impacts the LPHA's ability to meet budget goals, offer essential healthcare services and achieve the LPHA's mission.

Primary Job Functions *(±90%) - If needed, additional functions and responsibilities may be required.*

- Assembles documents required for credentialing and re-credentialing.
- Completes appropriate Iowa Universal, CAQH and health insurance plan applications.
- Secures appropriate insurance company contract forms and appropriate signatures.
- Submits completed application packages to health insurance companies.
- Follows up on pending applications to help ensure timely approval.
- Promptly resolves any requests for additional information received from insurance companies.
- Updates facility and provider information as required.
- Maintains required files of facility and provider documents and information.
- Complies with all HIPAA, and other regulations and requirements.

Special Requirements, Skills, Abilities and Qualities

- Requires a self-starter with the ability to work independently and as an effective team member.
- Attention to details, and adherence to established policies and procedures required.
- A problem solver with the ability to organize and prioritize responsibilities.
- Is flexible, and able to embrace and implement change.
- Effective oral and written communication skills.
- Good natured with a positive attitude and a smile; always courteous and respectful to co-workers.
- Always courteous and respectful regardless of race, creed, personal and/or economic situation.
- Finds helping people who need the LPHA's services rewarding and fulfilling.
- Minimum of high school diploma or equivalent.
- Touch typing/keyboarding with speed and accuracy.
- Working knowledge of Windows personal computer, Microsoft Word and Excel.
- Prior credentialing experience a plus.
- Knowledge of credentialing software a plus.

Please note that a financial and legal background check will be required. Must pass county physical examination, which includes a drug test after offer of employment.

Job Description

(Name of LPHA)

Billing Specialist

Reports To: *(_____)* **Department**: *(_____)* *(Full Time/Part Time/Exempt, Temp)*

Major Responsibilities

The Billing Specialist is responsible for filing claims with, and processing payments from, government and commercial health insurance plans and individual patients.

Scope and Impact

The billing specialist is a direct link between the LPHA and those insurance plans and individuals that have been billed. In the course of generating claims and receiving payments, the billing specialist interacts directly with LPHA management, providers, insurance plan representatives and clients. The claims generated represent significant revenue, and impact the LPHA's ability to meet budget goals, deliver essential healthcare services and achieve the LPHA's mission. Accuracy and productivity are mandatory.

Primary Job Functions *(±90%) - If needed, additional functions and responsibilities may be required.*

- Receives, reviews and enters claim information into computerized billing system.
- Submits claims for payment.
- Follows up on pending claims to help ensure timely payment.
- Promptly resolves issues related to claim denials.
- Receives payments, reconciles with Explanation of Benefits, then posts as appropriate.
- Maintains required files of all appropriate documents and information.
- Complies with all HIPAA, and other regulations and requirements.

Special Requirements, Skills, Abilities and Qualities

- Requires a self-starter with the ability to work independently and as an effective team member in a professional environment.
- Attention to details, and adherence to established policies and procedures required.
- A problem solver, with the ability to organize and prioritize responsibilities.
- Is flexible and able to embrace and implement change.
- Effective oral and written communication skills.
- Good natured with a positive attitude and a smile; always courteous and respectful to co-workers.
- Always courteous and respectful regardless of race, creed, personal and/or economic situation.
- Finds helping people who need the LPHA's services rewarding and fulfilling.
- Minimum of high school diploma or equivalent.
- Understands and can do basic math without a calculator. Can balance his or her own checkbook.
- Touch typing/keyboarding and touch10-key, both with speed and accuracy.
- Working knowledge of Windows personal computer, Microsoft Word and Excel.
- Knowledge of medical billing software a plus.
- Knowledge of medical terminology and coding systems a plus.
- Prior medical insurance billing experience a plus.

Please note that a financial and legal background check will be required. Must pass county physical examination, which includes a drug test after offer of employment.

Job Description

(Name of LPHA) **Enrollment/Billing Specialist**

Reports To: *(_____)* **Department**: *(_____) (Full Time/Part Time/Exempt, Temp)*

Major Responsibilities

This position is responsible for two key functions - enrolling *(credentialing and contracting)* healthcare providers with Medicare, Medicaid and other health insurance plans; and billing *(filing claims and reconciling payments from insurance plans and patients)* for services delivered to plan members.

Scope and Impact

The enrollment/billing specialist is a direct link between the LPHA and medical insurance plans, and interacts directly with LPHA management, providers, insurance plan representatives and patients. The complete, accurate and timely execution of the enrollment and billing responsibilities directly affects the ability of the LPHA to generate significant revenue. This impacts the LPHA's ability to meet budget goals, offer essential healthcare services and achieve the LPHA's mission. Accuracy and productivity are mandatory.

Primary Job Functions - *If needed, additional functions and responsibilities may be required.*

Enrollment *(±10%) - Establishing proof of professional standing and contracting with insurance plans.*

- Assembles documents required for credentialing and re-credentialing.
- Completes appropriate Iowa Universal, CAQH and health insurance plan applications.
- Secures appropriate insurance company contract forms, and appropriate signatures.
- Submits completed application packages to health insurance companies.
- Follows up on pending applications, and promptly resolves requests for additional information.
- Updates facility and provider information as required.
- Maintains required files of facility and provider documents and information.

Billing *(±80%) - Filing claims with, and receiving payments from, insurance companies and patients.*

- Receives, reviews and enters claim information into computerized billing system.
- Follows up on pending claims to help ensure timely payment.
- Promptly resolves issues related to claim denials.
- Receives payments, reconciles with Explanation of Benefits, then posts as appropriate.
- Maintains required files of all appropriate documents and information.
- In all activities, complies with all HIPAA, and other regulations and requirements.

Special Requirements, Skills, Abilities and Qualities

- Requires a self-starter with the ability to work independently and as an effective team member.
- Attention to details, and adherence to established policies and procedures required.
- A problem solver, with the ability to organize and prioritize responsibilities.
- Is flexible when situations require, and able to embrace and implement change.
- Effective oral and written communication skills.
- Good natured with a positive attitude and a smile; always courteous and respectful to co-workers.
- Always courteous and respectful regardless of race, creed, personal and/or economic situation.
- Finds helping people who need the LPHA's services rewarding and fulfilling.
- Minimum of high school diploma or equivalent.
- Understands and can do basic math without a calculator. Can balance his or her own checkbook.
- Touch typing/keyboarding and touch10-key; both with speed and accuracy.
- Working knowledge of Windows personal computer, Microsoft Word and Excel.
- Prior credentialing and/or billing experience a plus.
- Knowledge of medical credentialing and/or billing software a plus.
- Knowledge of medical terminology and coding systems a plus.

Please note that a financial and legal background check will be required. Must pass county physical examination, which includes a drug test after offer of employment.

(LPHA Name)

Patient Registration

Date: ____/____/_____ Patient Sex: Male Female Date of Birth: ____/____/_____
DD MM YYYY *(Circle One)* *DD MM YYYY*

Patient Name: _____, _____ _____
Last Name (Family Name) *First Name (Given Name)* *MI*

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone - Home: _____ Cell: _____ Work: _____

E-mail: _____

Employer Name and Address: _____

Social Security #: _____ Spouse's Name: _____

Previous Family Physician *(if applicable)*: _____

Emergency Contact *(Other than Spouse)*: _____

Relationship to Patient: _____ Phone Number: _____

PATIENT INSURANCE: Does the patient have, or is the patient covered by health insurance? *(Circle One)* Yes No

1. **PRIMARY** Insurance Company Name:_____

   Address/City/State/Zip_____

   Policy Holder *(Insured's Name)*: _____ Policy Holder Date of Birth _____

   Policy Number: _____ Group Number _____

   What relationship is Policy Holder to the Patient? *(Circle One)*: Spouse Child Self Other: _____

   Is policy through Employer? If Yes, Employer's Name: _____

2. **SECONDARY** Insurance Company Name: _____

   Address/City/State/Zip_____

   Policy Holder *(Insured's Name)* _____ Policy Holder Date of Birth _____

   Policy Number _____ Group Number _____

   What relationship is Policy Holder to the Patient? *(Circle One)* Spouse Child Self Other:_____

   Is policy through Employer? If Yes, Employer's Name: _____

   Effective Date of Policy:_____ Work Phone: _____

PATIENT'S RACE/ETHNICITY: Black/African American Asian/Pacific Islander Latino White Other: _____
---------- (*Circle One*) ----------

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Over

(LPHA Name)

Patient Registration

MESSAGES REGARDING THE PATIENT:

___ **Yes,** ***(LPHA Name)*** has my permission to leave voice-mail messages in regard to appointments, lab results and other information related to patient visits. My preferred number for messages is: _____

___ **No,** I would prefer that ***(LPHA Name)*** not leave *detailed* information on my voice-mail other than messages for me to call the doctor's office.

CONSENT TO TREAT: I authorize the ***(LPHA Name)*** healthcare providers to administer treatment as deemed necessary for care of the patient named above. I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to ***(LPHA Name)*** for any services furnished to me by the ***(LPHA Name)***. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

My signature indicates that all information provided above is true and accurate:

_____ _____
Signature of Patient or Legal Representative *Date*

If patient is under the age of 18:

Full Name of Parent or Legal Representative: _____

Address if different than your own: _____

City _____State _____ Zip _____ Day Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(LPHA Name)

My signature below indicates that I have been given an opportunity to read this practice's NOTICE OF PRIVACY PRACTICES and to have any questions answered before signing.

Signed: _____Date: _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:
[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of an incompetent patient
[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY: Employee Signature: _____Date_____

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____

Name of Clinc
Address Line 1
Address Line 2

Date of Service:	*Insurance* Provider:
Patient ID:	*Insurance* ID:
Patient Name:	Provider:
Patient Date of Birth:	**Note: Modified for project to identify ICD-10 columns, and include Gardasil9, CPT 906**
Patient Gender (circle one): M / F	**See Tabs Below for page 2 and Printing Instructions.**

Evaluation and Management Codes (Time in Minutes)		**ICD-10 DX**	**CPT**	**$**
New Patient Office Visit	Problem Focused-Straightforward (10 min)		99201	
	Expanded Problem Focused-Straightforward (20 min)		99202	
	Detailed-Low Complexity (30 min)		99203	
	Comprehensive-Moderate Complexity (45 min)		99204	
Established patient visit	Follow-up (presenting problems minimal) (5 min)		99211	
	Problem Focused-Straightforward (10 min)		99212	
	Expanded Problem Focused-Low Complexity (15 min)		99213	
	Detailed-Moderate Complexity (25 min)		99214	
	Detailed - High Complexity (40 min)		99215	
Procedure Codes				
Injection Administration-Medication	Subcutaneous or Intramuscular		96372	
Other Procedures				
Wart Removal (Simple vs Extensive: Provide judgement based on time, effort, complexity and number and size of lessions.)	Vulva; simple		56501	
	Vulva; extensive		56515	
	Vagina; simple		57061	
	Vagina; extensive		57065	
	Anal; simple		46900	
	Anal; extensive		46924	
	Penis; simple (cryosurgery)		54056	
	Penis; extensive		54065	
Preventative Medicine Counseling	~15 mins		99401	
	~30 mins		99402	
	~45 mins		99403	
	~60 mins		99404	

Modifiers	
22	For when a procedure was more **complicated** or **took more time than usual** (i.e., passing out during blood draw)
24	For a service performed during **post-op period (10 days)** and **unrelated** to original op
25	For a significant, separately identifiable service on **same day** as original procedure
33	For a visit **preventative** in nature
58	For **staged procedure** within **10 days of original procedure** (same problem with diff't stages to address fully)
92	For use with rapid HIV tests; "alternative lab platform testing"

Hold for Future Use				

*When counseling and/or coordination of care comprise more than 50% of the typical time for a vist, it is permissible to use time as the driving factor to report CPT code.

Name of Clinic - page 1 of 2

Laboratory Codes		**ICD-10 DX**	**CPT**	**$**
	UHCG-Urine Pregnancy		81025	
	Wet mount		87210	
	Venipuncture		36415	
	PPD Plant TB		86580	
	Gram Stain		87205	
	Urinalysis (Dip stick)		81003	
	Glucose-Fingerstick		82962	
	Total Cholesterol Screening (HDL, LDL +TRG)		80061	
	Rapid HIV-1/Initial CMS test		86701	
	Rapid HIV-1/2		86703	
	Hep C-Rapid		87902	

STD Tests	**Labs sent to State Lab for Processing-Use for Tracking Only**			
	VDRL - Syphilis			
	Gonnorrhea			
	Chlamydia			
	Hepatitis			
	Herpes Culture			

Medication Codes				
	Zithromax - per 500mg		J0456	
	Ceftriaxone - per 250 mg		J0696	
	Bicillin - LA per 100,00 units		J0561	
	Other Medication			
Hepatitis	HAV/HBV Combo (Twinrix)		90636	
	HAV (Teen/pediatric; 2 dose sched)		90633	
	HAV (Teen/pediatric; 3 dose sched)		90634	
	HAV (Adult)		90632	
	HBV (Teen; 2 dose sched)		90743	
	HBV (Adult) (3 dose sched)		90746	
	HBV (Immunosupp or dialysis pt; 3 dose sched)		90740	
	HBV (Immunosupp or dialysis pt; 4 dose sched)		90747	
	HBV (Teen/pediatric; 3 dose sched)		90744	
HPV	Gardasil (3 dose sched) *Requires NDC# from package		90649	
	Gardasil9 (3 dose sched) *Requires NDC# from package		90651	
	Unclassified drug (use for Aldara)		J3490	

Diagnosis Code(s) :	
Previous Balance	
Total Charges	
Payments	
Balance Due	