HIV Prevention Billing Opportunities: Setting Fees

Alexia: Welcome everyone. Thank you so much for joining us today for the HIV Prevention Billing Opportunities webinar series. This is the Setting Fees webinar. Today, we will have myself, Alexia Eslan, from JSI Research and Training Institute presenting as well as Roberta Moss from Moss Healthcare Management Consulting.

I am the CBA@JSI project manager and we provide capacity building assistance to community-based organizations throughout the US to do HIV prevention work and we do that in many different areas, and one of them being getting ready for billing, contemplating billing, and what are the systems you need to have in place. We do a lot of monitoring and evaluation capacity-building assistance as well. We help with different behavioral and science-based interventions, we train on those, and also how to adapt them to your communities. Then we do a lot of other organizational management capacity building assistance as well as, for example, strategic planning, getting ready for the implementation of Affordable Care Act in your settings and so forth.

I'm going to let Roberta introduce herself and then we will move forward with the content for our presentation today.

Roberta: Hi. I'm Roberta Moss and I'm a consultant working with public health entities as they adapt to healthcare reform. Formally, I was the chief operations officer of a reproductive health organization with family planning, STD clinics, and HIV prevention education and counseling and testing sites. Prior to that, I had several years of private practice group medicine in the following specialties: OB-GYN, internal medicine, ophthalmology, and anesthesia. I have a [00:02:00] lot of knowledge about medical billing and clinic operations. Alexia?

Alexia: Great. Thank you, Roberta. We are really privileged to have Roberta with us today. She is extremely knowledgeable and she will be actually doing most of the presentation. We are really looking forward to getting as well your questions as we go through the presentation. You can either type those in the questions/commends pod that is on the bottom-right of the screen or you can unmute your line by pressing star 6 and you can ask it via the phone. There's also a raise hand function in Adobe Connect and that's on the top toolbar. That's a little person that has a hand raised. If you click on that icon, it will actually raise your hand and it works as a toggle, so if you click on it once, it raises your hand. If you click on it again, it upraises your hand. If you do have a question and you're not able to ask it, please go ahead and raise your hand and then we will give you the floor for you to ask it via phone.

Here is an agenda of what we are going to be covering during our webinar today. We're going to be talking about what changes are creating pressure for change,

defining different billing models, how your organizational structure may determine your strategy, defining reimbursement goals, so really giving some thought to, depending on what your billing model will be, what that organizational structure is and what your goals are around it.

Then we're going to dive into the main portion of the presentation which is setting fees and giving two different tools that assist with that. One is sliding fee scales which is specifically for billing clients and then superbills which allows you to use CPT codes [00:04:00] and other codes to determine how much you would be billing to like Medicaid or to other third-party insurance companies. Then we will wrap it up with some special considerations specifically for HIV Prevention services.

Throughout this presentation, we will be talking about giving examples specific to the work that CBOs do in HIV prevention and the superbill that we will be sharing … We actually have a tool that we will be sharing with you … has been tailored to HIV prevention. The objectives for today's webinar are three. It's by the end of the webinar, you'll be able to explain the various models for HIV prevention and education reimbursement; explain the basic steps to prepare for billing including superbill and sliding fee scale development and implementation; and the last is be able to list three or maybe four or two special considerations unique to HIV prevention billing.

Without any other pause, I'm going to hand it over to Roberta who will now dive into the content.

Roberta: Hi. Thank you. Where is your organization? There's this idea that there's more opportunity now because more clients are insured as a result of the ACA. The CDC had the expectation that safety net providers need to develop alternative sources of revenue. These are challenges that are unique to HIV prevention services. Medical reimbursement is designed with a physician-based medical model. Like many safety net and public health services, HIV prevention services are designed on a different model, a community-based model of care, so sometimes doing these things feels like you're trying to put a square peg into a round hole.

Also, the public health bureaucracy does not go away [00:06:00]. The collection of demographic and epidemiological information and reporting continues. This runs parallel to reimbursement. Some states have adapted ACA, some have not; some have expanded Medicaid, some have not; some have state exchanges, some don't. Across the nation, people are in different places in regards to your changing reimbursement landscape. However, you can't continue to depend solely on CDC or state DPH funding. There exists uneven and uncertain funding

or trend towards decreased funding. As public health professionals, we're used to doing more with less. However, without new sources of revenue, there's a tipping point where organizations cut programs that are no longer able to serve their community. In order to survive, organizations merge or maybe the mission is altered, and the worst case scenario, organizations close.

The question is what are you goals and what can you do to ensure your survival in the new healthcare marketplace? Alexia?

Alexia: Great. Now, let's run a quick poll. If everyone could please take a minute, you have a poll right there. It says, "What are your organization's interests?" Do you want to receive reimbursement for the services you provide, operate like a small medical practice, continue to provide services with grant funding, outsource billing, or get more information so you can make a decision? Basically, you still don't know and you're just trying to research. You can select as many as are applicable. Let me give you another 30 seconds to do that.

[00:08:00] Okay, great. I'm seeing a lot of responses around receiving reimbursement for the services you provide, so looking at those models. One person, operating like a small medical practice, so becoming some kind of, if you could become a [inaudible 00:08:18] look alike or there's different models there; continue to provide services with grant funding. Seven of you will still be looking at that, and that might be actually in conjunction with receiving reimbursement for the services you provide. Really, looking at the two streams. Outsource billing, two that are interested in that and tehn seven get more information. Great. Thank you for participating of the poll, and now let me give it back to you, Roberta.

Roberta: Thanks. We can look at some different model options that might be helpful. One is to partner. You could partner with a community health center or other safety net provider. The benefit to you is you continue providing services to your community; the benefit to the health center is they could subcontract out this specialized and essential service; and the benefit to the community is that they'll continue to receive these services with staff who are experts in this area. The community health center reimburses your organization to provide HIV prevention services or they might let you co-locate, unless you can significantly reduce your overhead. Or they could provide you with administrative support.

In this model, the CHC would pay the CBO directly in the form of a cost grant or unit reimbursement per encounter or per client. A cost grant is when the budget has line items such as staff, supplies, rent, computers, etcetera and unit reimbursement is they pay you a set amount, say $50, for every patient you see. What you [00:10:00] should do is you should conduct a cost analysis. You know

how much it costs to provide your services and then base your charges either on that analysis or perhaps on Medicare or Medicaid rates. I would be careful here because with Medicaid rates, Medicaid rates are often very low, so you might be better off looking at your local Medicare rates.

Another option besides partnering is to bill Medicaid. The benefit to you is increased revenue or replace revenue in case of reduced or lost grant funds. The benefits to the client is they can receive services that are covered by Medicaid. The challenge is it's not possible to only bill Medicaid and not bill clients or other third-party payers. While it seems attractive to bill Medicaid and not patients who sometimes don't have Medicaid and can't afford care, it is expressly forbidden by Medicaid regulations.

An issue is price fairness. When billing a third-party such as Medicaid, Medicare, or any other third-party, you must always charge the same amount for each service. For example, if Medicare wants to pay $50 for an HIV test and you bill Medicaid $50, you must also charge everyone else $50. If they discover that you're charging your other clients, say, $25, then they have the right to collect back that $25 from you along with interest, penalties, and the possibility of being barred from the program.

Questions to ask your organization to determine if billing Medicaid is possible include things such as who are your providers. In order to bill Medicaid, you will need licensed providers such as MDs or MPs to contract with Medicaid. Are you a healthcare organization with a medical director? If you are contracting as a clinic or with a mid-level provider such as nurse practitioners or physician's assistants, you will need a medical provider as well. Are you a social service [00:12:00] community-based organization? You will probably not meet Medicaid requirement to provide medical care. Has your organization ever billed for any clinical or testing services? Does your organization have any historical and/or internal capacity to bill for services? Who provides your clinical supervision? What are your services and do you provide any other medical services?

Yet another option is to expand into third-party billing. That would be billing private insurance companies such as Blue Cross Blue Shield, Aetna, Prudential. The benefit is they generally reimburse at a significantly higher rate than the Department of Public Health contracts or Medicaid. As more people become insured, more people will be interested in using their insurance. The challenges include a steep learning curve for credentialing, contracting and negotiating fees. You will need some staff to do this work but you do not need a whole billing department. The rule of thumb is to have 10,000 claims per biller. Most HIV prevention and education programs are much smaller than that. Then also, if you're looking at third-party billing, you also might be concerned about

confidentiality and having people use their insurance and what becomes of the explanation of benefits. These are other concerns that you need to account for.

Just to review in terms of third-party billing, credentialing is having each provider in your organization complete an application with their complete CV, work history, malpractice history, license information, and other personal demographic information to be submitted to the insurance company to be processed and approved by their board. These boards typically meet quarterly to review and approve provider and clinic applications.

Contracting is actually reviewing the contract the insurance company presents to you after your application is approved. It will include [00:14:00] such stipulations as how many days you have to submit claims, how to dispute denied claims, requirements for claim submission, the length of the contract, if any periodic review must be provided for them. It will also include the amount they will pay you for each type of service you provide as well as the scope of services they are contracting with you for.

Finally, negotiating fees is the formal negotiation when your organization proposes a different level of reimbursement for a service that's stated in the original contract. You would try to negotiate for higher fees or perhaps a more frequent review of those fees. As a small organization, you often do not have a great deal of control in this area of contracting, but it's important to keep this in mind.

There are opportunities and those opportunities include partnering with other like organizations when you approach these insurance companies. That way, the companies will be able to more easily understand who you are and what you do. As I said, they're used to dealing with medical practices, so safety net providers provide a model care they're not used to dealing with on a daily basis. Also, some hospitals or community health centers who do have experience with credentialing, contracting, and negotiating fees, they can assist other health safety net providers such as yourself or your agency, and they will consider this to be providing a community benefit.

The last option I'm going to talk about is billing clients directly for services either using a sliding fee scale or a flat fee. Recognize that out of all of these models, this might require the largest cultural shift. The trend in many public health departments now is to issue grants to provide behavior-based funding for individual encounters [00:16:00]. What I mean by that is some visits will be covered by the grant. For example, if the client engages in certain behaviors such as IDUs or MSMs, while others are often referred to as the worried well, and they are perceived at reduced risk, the non-grant covered clients must pay for

their service with insurance or out of pocket. Organizations often want to serve their community and see these non-grant clients to maintain productivity and fiscal health. Most organizations cannot survive on grant funding alone. Billing non-grant clients on a sliding fee scale or by flat fee is a way of maintaining volume.

How is your organization poised to ascertain that information prior to the delivery of services? How can you find out if they're eligible for the grant funding or the insurance or if they have the means to pay for those services? Probably in order to do this, you'll need to include some staff training in whatever path you take. Collecting a fee directly from clients is a way to maintain fiscal health and client volume. The answer for your agency might be a combination of models. You could have a combination of a sliding fee scale and partnering with the community health center, or you could have a progression of models. For example, first you could develop a sliding fee scale while you're obtaining the insurance contracts for the most popular insurances in your area. You don't have to contract with everyone.

How does your organization structure perhaps determine what strategy you can select? For example, if you're purely a social service organization, some of these third-party insurance reimbursement scenarios may not work for you. Alexia?

Alexia: Okay, let's run another poll [00:18:00] to get a sense of where you're at given the models that Roberta just talked about. What models are you considering? Having a partnership with another organization that does billing; bill Medicaid; bill third-party insurances like managed care organizations or health maintenance organizations; bill clients directly; or none of the above? Again, this, you can choose all that apply. You might be thinking of using a few different models depending on what your goals are. As you're completing this, just a reminder, if you do have any questions while we go along, please make sure to enter them in the questions/comments box.

Okay, so this was really interesting. Everyone is pretty spread out. It feels like everyone is interested in most of the different models, partnerships and billing Medicaid being the most popular, which is what we've seen the most, but then a lot of you looking also to bill third-party insurance companies. I'm surprised actually about the billing clients directly, seven. That's actually good to see because I know it's a big culture shift for us to start billing clients directly, but it is definitely a good alternative. I see Ron has a question. Does billing clients include sliding fee? Yes, it does. The sliding fee would be to actually be able to bill clients and Roberta will be talking a lot more about sliding fee scales in just a bit.

Rodney has a question here. I'm a little confused about partnership with CHCs [00:20:00]. Do you mean that CHCs would do the billing? Yes, so that is the idea, and Roberta, please chime in, that you would partner with a community health center or some other clinical provider that is already billing. You would provide certain services for them, you would have an agreement with them, they would reimburse you for those services and then they will take care of the billing to, say, Medicaid or third-party insurance companies.

Roberta: Or they could pay you directly through some other grant that they have as well. They could do your billing for you or they could act as a substitute grant holder.

Alexia: That's a great point too. The benefit I'll answer and then, please also, Roberta, chime in, is that for example, say, a community health center might need to reach certain hard to reach populations and you might have better access to this population and so you might be able to reach out to them, di maybe, say, HIV testing and initial counseling with them and then refer to them to the CHC. The CHC will be interested to reach that population and since you have that access they will be interested in contracting with you to do that. It really depends on what the goals of the CHC are, what your goals are and making sure that they align and that you both have interests in common.

Roberta: I think, Robyn, we'll be talking about prevention services and reimbursement a little bit later [00:22:00] in the presentation. I think that I can answer your question then.

Alexia: Great. Thank you. Let's go ahead and move on and then, yeah, please continue sending your questions as we move along.

Roberta: Now I'm going to take a few minutes to talk about sliding fee scales. Sliding fee scales, the benefit of sliding fee scales is that they're variable prices for products and these fees are thereby reduced by those who have lower incomes or have less money to spare after their personal income. It's a form of differential pricing. The benefit is clients are charged based on their income. The challenges are maintaining the fiscal administration of the sliding fee scale including discounts and write-offs. There's staff training to discuss income with clients, and you also want to think about what portion of your services would you want to include on a sliding fee scale.

Sliding fee scales are viewed as a fair way to create income for your organization while at the same time being responsive to low income clients. HIV prevention education programs, like many safety net programs are very sensitive to the challenges of their client's life. I'm assuming that in all of these models, no client would be turned away for their inability to pay for the services. This can be

achieved by sliding the scale to zero or no cost or by allowing staff to provide hardship discounts to clients on an individual basis. HIV prevention services often include individual counseling, harm reduction counseling, pre-test counseling, post-test counseling, group activities, case management, other STD tests such as chlamydia and gonorrhea or syphilis, hepatitis testing, HIV awareness and educational events in your community. You need to decide what services you would want to slide.

Sliding fee scale [00:24:00] has five components. The first, you would create a table that divides the poverty levels into proportional sections by family size. You then collect the demographic and income information from the client. You assign the client a place on the scale, you create a table of fees with each charge plotted on the table by poverty percentage or level, and then you calculate a patient's fee from the encounter based on their placement on the scale. I'm going to go through each of the five steps.

First you create a table that divides the poverty levels into proportional sections by family size. Many organizations divide the poverty levels into six sections, say, 0 to 100 percent of poverty, 101 to 125 percent poverty, 126 to 150, etcetera. Some organizations even have 10 or 12 steps, but I think that gets a little complicated. The US Department of Health and Human Services, usually around March of each year, publishes the annual poverty rate. Some organizations do not charge or only minimally charge for clients who fall under a 100% of poverty. Several federal and state programs mandate this level of free or deeply discounted care. If you have a federal or state grant that requires you to collect income information, I suggest that for your sliding fee scale, you use the same interval your grant requires such as weekly or monthly income.

Here's a sample sliding fee scale that uses annual income. You can see on the last are the family unit size, family size of 1, 2, 3, 4, etcetera and then going towards the right, they've divide it. You could see a 100% in poverty, 125% of poverty, so they're assuming in this scenario that people at a 125% of poverty would pay 20% of the total bill or their services would be [00:26:00] discounted by 80%.

Here's another example with smaller income breakdowns. Again, on the left, we can see the family size, and then we can see going across that they are now breaking this down at a 100% of poverty, 110, 120, 130, and then assuming what they're calling in their organization the co-pay for each visit would be $25, $25, 30, 30, 35, 35, etcetera.

After you've done this, you need to collect the demographic and income information from the client. This is usually done by having the client complete a paper form. Some organizations collect this information on the phone prior to

the visit, some do it when the patient first arrives in the office, some collect this information verbally from the client. Obviously this information is sensitive. You need to create a confidential area to discuss this kind of information with clients. Also be mindful to keep as separate as possible income information from other clients of sensitive health information in your records.

Here's a sample intake form. This is the part that perhaps staff member might help client complete. You would look at money from a job, the amount you make before taxes but after tips, your hourly wage times how many hours you work will give you a weekly wage. You also might want to remind your clients that you're also thinking of income, not just from a job but also spousal income, income from a partner, a parent's job, alimony, worker's compensation, unemployment, things like that. Then you would have the family size. Then you can convert that to, say, a patient level, so you could call them patient level A or patient level 1 [00:28:00], as opposed to patient level 125% of poverty. Alexia?

Alexia: Great, okay. Thank you, Roberta, very much. Let's take another quick poll. This one is about just getting a sense of what information are you currently collecting from clients. Let us know all that applies because the way this links is depending on the information that you're getting, obviously depending … because you need to gather some information to be able to build. It's good to get a sense of right now what kind of information are you already getting. So name, address, age, everyone's getting; family size, income and insurance information, actually five. Five of you are currently getting that. Great. Thank you for sharing. Again, if you have any questions, please submit it via the chat and we'll go ahead and move forward.

Roberta: Thanks. Then you're going to assign the clients on your sliding fee scale. For example, looking at this sliding fee scale, so one with this family size of four and family income of $25,000 would fall as a minimum fee client as their income falls between above 100% of poverty and under 125% of poverty. Another example would be client B, family size of one and income of $25,000. This person would pay 100% of the bill because his bill is over 200% of poverty. Client C, perhaps they have a family size of seven and a family income of $60,000, so he would fall at the 40% pay level.

Sometimes you really need to work with the clients [00:30:00] to determine income. Often people have roommates but they're not part of their family unit, so their income is not included. Some people have partners but they don't have access to their income so they would have a family size of one. Some people do not consider worker's compensation or disability as income. While each person's situation is unique, after some experience your staff will begin to get the hang of this. Your organization can create business rules to guide staff in this process.

For example, some people have seasonal work. Your organization can decide to divide that income across the entire year, thus lowering any weekly or monthly assessment. This way, people won't feel they should skip care during periods of employment. You should do this for every patient and keep the information together with your other demographic information and not your clinical information, as I've mentioned earlier. Annual updating of this information is normal and you can update sooner if the client's financial situation changes.

Alexia: Roberta, we have a couple of questions that came in. One from Lisa which says people with coverage, for example, subsidized exchange plans, should have access to testing without co-pay. Can they recover these fees from their plans?

Roberta: Not exactly. They should be able to have received these services that would be billed to their plan so they would not be charged for them.

Alexia: Testing is considered like a preventative care so there's not a co-pay aligned with it typically.

Roberta: Right. They would be considered covered services by contracted providers and that's why they would receive those services at no cost to the client as long as you bill the insurance company. I also-

Alexia: Great. [00:32:00] Go ahead, Roberta.

Roberta: I also see the question about the health department in D.C. going up to 500% of poverty. That's fine. You can have at the top of your scale whatever works for you. This is just an example. Typically a lot of safety net programs go up to 200 to 300 percent of poverty, but that's not set in stone. What if the provider is not set up to build the plan is the last question, and unfortunately, if the provider is not set up to build the plan, they can't get reimbursed for their services. Sometimes people can try to submit claims for outside of network and depending on the plan the client has, that may or may not be covered service.

Alexia: Yeah, I think that's an important point that if you don't have a provider that is actually set up for billing or is not licensed provider that can bill, then you can't bill for the service even if that client or patient does have insurance.

Roberta: That's right. If the Health Department has a sliding fee scale format and you like that format, then go ahead, yes, go ahead and adopt it.

Alexia: Yeah, I know that actually. I'm in Colorado and Colorado does have a standard sliding fee scale that they use and that the state department has, and so many of the CBO's or community health centers do adopt that sliding fee scale.

Roberta: Right. Now we're going to getting to the part of the sliding fee scale that is unique to your organization. You're going to now create a table of fees with each charge plotted on that table by poverty percentage. This is really simple one here. There are office visits, if you're under 100% [00:34:00] of poverty, are $15 or $35. Let's take a look at another one here. Here's another one. We have visit types here on the left with their CPT codes attached and then the patient columns and then we'll take a more detailed look at this in just a moment. You would set up something like this with all of the kinds of services you want to have on your sliding fee scale.

Now what you're going to do is you're going to calculate the client's fee for an encounter based on their placement on the scale. I see Fran's question about peer specialists who are not licensed, can they bill for prevention services. I'm going to get to that. That's like the non-licensed provider question and we'll get to that in just a little bit, but I will not forget that question.

Here now we're looking at the sliding fee scale. I'll give you just a few examples. For example, if a client is a level 1 client, so she's new, she comes in, she has a minimal visit and a chlamydia test for $10. Her total charges are $60, but because she is level 1, she's only charged $5 for her visit and there is no cost for the chlamydia test, thus she saves $55 for that encounter.

Another example might be client number two, and he's a level 3 established client. It's under level 3 and he comes in and has a minimal visit for $50 and an HIV test for $50, so his charges total $100, but because he's a level 3 [00:36:00] client, he's only charged $20 for his visit and $20 for his test, for a total of $40, so thus he saves $60.

There's another option besides doing a sliding fee scale. The other thing that you could do also is you could, instead of using a sliding fee scale, you could charge a minimal flat fee to all of your clients. You could then use grant dollars to offset charges for clients who don't have or don't want to use their insurance and there's special considerations when you're doing this with HIV prevention clinics. One is what are your scope of services, if there's significant issues about confidentiality and insurance. Sometimes you will discover that people are willing to use their insurance but you have to ask. There's also the question about what to do about teens. Do you have special rules about teens and charging teens? Whether the special rules are business practices within your own organization or mission practices within your organization, or perhaps you might have a grant that specifically says how you can interact with teens in terms of reimbursement.

Other things to think about is your state's HIV consent rules, so how and when do you obtain those and how does that affect how you might operationalize

billing. How does that affect your patient flow, your client flow in the clinic? Do you ask about income and insurance and consent prior to the visit, during the visit? How does this affect your client flow? How does this affect your staffing? Who becomes responsible for obtaining this information from the client [00:38:00]?

Another thing to keep in mind, you may be doing anonymous testing that's running parallel with confidential testing. Perhaps you might be looking for a third-party or Medicaid reimbursement for your confidential testing, but you're still going to have the anonymous testing going on at the same time and that often has different protocols and guidelines and a different flow through your clinic.

Alexia: Roberta, you saw there's a quick question here about is an HIV prevention clinic the same as a non-clinic ASO?

Roberta: I'm using the word clinic very broadly. I'm using the word clinic to suggest any organization that's providing clinical services. It could be an STD clinic, it could be a health department, it could be part of a hospital-based clinic, it could be a walk-in center. I'm using this word very broadly. Are there any other-

Alexia: A lot of community-based organizations- … I was just going to say many community-based organizations do offer some clinical services, and so that would also fall within that kind of broad terminology.

Roberta: Mm-hmm (affirmative). Are there any other questions regarding the sliding fee scale?

Alexia: Remember, you can raise your hand if you want to talk via phone or you can chat your question. I guess not. Let's go ahead and move forward.

Roberta: Okay. Okay, so now we're going to kind of talk about superbills for a little while. Superbills and sliding fee scales are often used [00:40:00] in conjunction with one another. What goes on your superbill depends on what services you are providing. What is the intersection between HIV prevention, HIV counseling and testing, case management, and clinical care services in your organization? When using a superbill, a provider or a member of his or her staff will use one of these forms during every client encounter, checking up all the boxes that apply to the client. When the client's form gets to the office staff, then there's no guesswork involved. The staff bills the client or the client's insurance company or the partnering organization for the conditions and treatments the provider checked off and all the necessary codes are right there on the form.

Different types of practices use different superbills depending on what types of conditions and treatments they see most often. For example, a dermatologist superbill list will look totally different from say a cardiologist superbill. The superbill makes it easy to code all of the ordinary conditions that are addressed. The elements of the superbill. You collect client insurance and demographic information, the CPT codes, the ICD-9 codes, provider information, the clinic name, address and tax ID, and price information.

The Current Procedural Terminology, the CPT codes, refer to the specific services that may be performed during a client's visit. These are of particular importance in the third-party billing setting as they determine the reimbursement amounts being receiving from the third-party payer. The American Medical Association convene to panel to maintain and update these codes annually. There are codes covering every imaginable diagnosis and service. However, in HIV prevention service, you're more likely to use a defined set of codes based on the most common health complaints and services. It may then be helpful to develop an encounter form for superbill which lists [00:42:00] the most commonly used ICD-9 and CPT codes. That way it could be filled out by your healthcare provider or clinical staff. Then these codes will match the healthcare provider's notes.

What is coding and how does it relate to the superbill? Coding is the numerical expression of what, why, and how care is delivered. It quantifies for billing purposes what is contained in the clinical chart. It's important to note that billing codes much reflect the same level of care documented in that chart. Procedure codes, CPT, are used to identify what the clinician has done during the encounter. There are numerous tools available to assist in thoroughly documenting clinical services. Capturing billing codes could be done in many ways.

One of the most widely accepted techniques is the use of a superbill. All medical visits and procedures are listed by CPT code. There are visit codes, consult codes, procedures, diagnostic, and lab codes. All the codes have five digits and all these codes begin with the number 9; lab codes begin with the number 8. Once you start using them, you'll begin to recognize them.

Here's a copy of CPT Standard Edition. It's available printed and you can get it online. It's updated every year, but usually only a few codes change, usually in the lab or surgery sections. You could get this at Amazon. Lots of other bookstores have them. For HIV codes, you'll mostly use ENM codes and labs. That is evaluation and management codes. These codes are divided between levels 1 to 5 and new and established. Each code you associate with a price. Proper coding and documentation is that matching up a code to the information on the clinical

record, and this is important and there are many resources [00:44:00] you could use to help you access this information. Through JSI, has many resources; other organizations. There are many free resources available to you.

The ICD-9 codes, this is the International Classification of Diseases. This is the list of comprehensive list of codes that service the standard diagnostic tool to indicate disease, injury, symptoms, and reasons for the encounter as well as any other factors influencing the client's health whether that's new or existing. These codes are determined by the World Health Organization. ICD-9 codes are currently used in the United States and they are called as such because they represent the 9th iteration of this research. Coming up next year, there will be ICD-10 codes and they've been established but they're not yet implemented. There are many, many more ICD-10 codes and there are ICD-9 codes and you may have heard something about this. You're going to just be using a subset of those codes. Even though there might be 17,000 ICD-10 codes, you might only be using say 20 of them.

Alexia: Roberta we have a question from Ron that came in. Are there plans for non-clinical AIDS service organizations who do HIV and STD testing bill for these services? I believe the-

Roberta: I guess the question is who is the "they" in that sentence. It's generally medical insurance, third-party insurance companies don't feel an obligation to pay for non-medical services in their medical insurance. Some Medicaid [00:46:00] programs throughout the nation have special program that will pay for non-clinical public health services. These are usually small niche programs. You can sometimes find lead screening. You can find some case management services that Medicaid programs are beginning to pay for, and like that. This is where healthcare reform become very regional and you would have to check with your Medicaid provider.

Again, to answer Fran's question which is can community-based prevention program bill anything based on value-based billing, you would have to look at the contract with the third-party payer to see if they indeed are reimbursing for those kinds of services or not.

Back to just finish up with the ICD-9, here are some samples of ICd-9 codes. There are many, many different kinds of ICD-9 codes. You also notice that all the codes that begin with the letter V are considered preventative codes. There are many codes that are available in the book but are not reimbursed by insurance companies generally. Some of these, when you set up your billing, a lot of it is testing to find out, perhaps Blue Cross Blue Shield of Oklahoma wants to pay for this kind of service but Blue Cross Blue Shield of Michigan does not.

There's a lot of testing going on and [00:48:00] when you begin billing, then you can also work with your other like organizations to see how did they fare? What codes are they finding that they can be reimbursed for?

There's a relationship between the ICD-9 code and the CPT codes. There must be a direct connection between the diagnosis as demonstrated by the ICD-9 code and the service provided as demonstrated by the CPT code. It's critical that both administrative staff and healthcare providers understand how to code. While some clinic find it useful to have someone on staff who is certified in medical billing, others find that they are able to do this on their own. They can either partner with another organization or they could perhaps have an external billing specialist come in and just look at their coding, but not be someone who's on staff. Professional coder is not necessary for HIV coding. Professional coders are most important and you see the most often in hospitals, people who are interpreting surgical notes, very, very large organizations or perhaps a large community health center.

It may be helpful to develop an encounter form or superbill which lists the most commonly used ICD-9 and CPT codes that you use in your setting, so it can easily be filled out by the healthcare provider or clinical staff based on the healthcare provider's notes. The insurance company or partnering organizations need to know all of these because that's how they pay for your services and they usually pay your services based on the degree of difficulty. Your job is to make sure the insurance company properly reimburses you. I think the most important thing about the superbill is to have it be as friendly as possible. It should have the largest font you can possibly use and it should have 95% of what you do every day. Leave a blank [00:50:00] spot for writing in unusual codes. You can have this be in any format that you like.

So often the front of the superbill contains the demographic information about the client and the clinic, the CPT codes, and the charges, the discounts and payments, and the back contains the diagnostic reference. Alexia, I think we have one to look at and if you could just walk me through how to get it up.

Alexia: Yes, so if you want to just click on Share My Screen and then share your desktop and you can share the superbill with us. Those of you on-

Roberta: Can you see it?

Alexia: I'm sorry?

Roberta: Can you see it now?

Alexia: Not yet. Did you actually start the sharing?

Roberta: Hold on. I think it's coming.

Alexia: If everyone notice, when we were in the other screen, in the bottom-right, there was actually a file share and if you click on the superbill under the file share, you can actually download it. You can download it directly from this webinar and we can email it to you afterwards if you need to as well.

Roberta: Can you see it now?

Alexia: It's synching. I think just … At least on my computer it's loading. [00:52:00] Let's give it a few more seconds and if it's an issue we could always go to the slide with the drawings.

Roberta: Sure.

Alexia: Are others seeing it already? Could you use the questions/comments chat and let us know if you can see it in your screen? Everyone on the line, if you could just let us know via the questions/comments pod in the right if you can see Roberta's screen because I can see it through my computer but I think it could be just me. There it is. Okay, Roberta we can see it now.

Roberta: Okay, good. Okay, thanks and sorry for that delay. Just quickly to walk through, this is a sample superbill. It's currently being used by a STD and HIV clinic in Connecticut. We have up top the clinic information, the address, the zip code and then in the top section, things like you would put in date of service, patient ID, the patient name, date of birth, the gender, that kind of general demographic information and also information about who's providing the service and what kind of reimbursement they have.

Alexia, I think I'm just going to go back to the slides.

[00:54:00]

Alexia: Okay. We can see your screen.

Roberta: You can? Okay, all right, then I'll just keep going then. Here in the middle of the superbill, you have your evaluation and management codes, those are your visit codes and this is what I think a lot of people have been asking about. The thing with CPT billing is there is really only one code in all of the visit codes that can be used by a lay staff person, and that mean someone who is not mid-level or higher. You have your physician's assistants, your nurse practitioners, and your

physicians. They're eligible to use all of the codes. You also have community health workers, educators, RNs, LPNs, and medical assistants. Often those are the people who are providing HIV prevention services, I realize that, and the only code that you can bill insurance companies for is this 99211 code.

That's the code that can be reimbursed by non-clinical staff. Usually Medicaid pays, depending where you are in the country, Medicaid will also often pay, say, somewhere between 15 and 20 dollars for that visit. It is not a lot of money. It is assumed that this visit is a very brief visit. Even though that's not required, you could spend a great deal of time with someone as you might in HIV prevention services. The other codes that people are sometimes being reimbursed for, and again, this vary from insurance contract to insurance contract, are some of these behavior change codes. Also some insurance companies, but not all, do pay for prevention group counseling, but again, [00:56:00] you'll need to find out who you're contracting with and whether these codes will be covered in your contract. It's certainly an important part to discuss with them and to look at.

Over here on the right-hand side, we have some lab codes that someone might use. Then here on the bottom, we have the spot where the diagnosis code you would write in, any previous balance you might have, total charges, payments, and that kind of fiscal information. This is the front of the superbill. Let's flip it over to the back of the superbill.

In this sample, the back of the superbill, it has the ICD-9 codes that are most frequently used in that clinic. They just have them written down here so the provider would say, "We'd pick this code" and then flip it to the front and just write it in, and then who's ever doing the billing would get that information from the front of the superbill.

Then the next is was this any for you? This is what you're wrestling with. Do any of these new models of reimbursement, might they work for you? Perhaps you're looking to use some sliding fee scales or superbills, and what kind of strategic information do you need to collect in order to make some decisions. I believe there's a value in determining if any or all of this is right for you. This knowledge and information you gather can help you assess and make strategic decisions for the future of your organization and it'll help you whether you actually adopt … Having this information will help you [00:58:00] whether you actually adopt some of these strategies or not.

The question is, is all this billing worth the effort? There are some people, and here are some examples of successes, for example, I've been working with the Hartford Health Department. They are now contracting. They obtained a free electronic medical record and billing system. They are looking at adding new staff

because of the revenue they've been able to collect. Salem State University Health Department in Massachusetts never billed before but they're now collecting private insurance and Medicaid and they too are bringing in another provider to help the students.

The Portland Maine Health Department uses a sliding fee scale. They collect from clients and Health Quarters in Massachusetts developed a comprehensive billing system. At first, they were just trying to diversify their revenue, and now, because of reduced funding, it's no longer strategic choice, it's a financial necessity. Also Health Quarters partnered with an HIV prevention organization and actually brought the staff from the HIV program into their office, gave them free office space, gave them access to their clients, allowed them use of their rent, telephone, computers, etcetera. I think that was a very nice example of how both of these organizations were able to work closely together.

Your positive outcomes would include additional staff, additional profit, happy clients. I suggest that you make a mini-strategic plan or create a workgroup within your agency or with other like organizations and try to answer these questions? How would the shift in reimbursement affect the people you serve? If needed, will you change your service mix to adapt to what third-party payers are willing to purchase? Some of the people you serve will have insurance [01:00:00] for the first time. How can you help them understand their coverage? How does a shift in reimbursement affect who you are as an organization and your role in the community? Consider all these questions and the clients you serve as you create your billing system: Who can you partner with? What can you outsource? Who can you refer to? If you partner or outsource, what responsibilities remain and do you have the capacity to handle that?

There are many different alternatives. You don't have to do this in house and you don't have to do this alone. Don't reinvent the wheel. There are samples of all kinds of document and policies out there on the web. This is the National Coalition of STD Directors and they have some really great case studies, a very valuable resource. Also the STDTAC Billing Tool Kit. This is a tool kit designed to help publicly-funded STD clinics and labs decide whether to bill, how to develop billing systems, how to manage revenue cycles, how to start contracts, how to code, and then, of course, there is the capacity billing assistance at JSI. That website has also all sorts of tools and information to support you in this process.

Alexia: I highly recommend everyone to check this out because there is actually a previous webinar that we've done on like Billing 101 and cost analysis. The recordings and all the tools from those webinars are in here and I notice that some of the questions that were asked today were actually covered on some of

those webinars. Do please go to cba.jsi.com and do go to the billing resources and you can download a lot of that information that was previously covered.

Roberta: Thank you. Are there any other questions people have [01:02:00] at this moment?

Alexia: You might take a minute to send us your question. I wanted to remind everyone that next Thursday, on the 19th, we will have a session with … It's basically like a panel discussion. We will have four experts on there and Roberta and myself will be on that webinar. We will do a slide presentation talking about some of the tools available and then we will have open Q&A. Please do make sure to put that on your agenda and you do need to register for that. We did send an email out and we will send another one closer to the date as well. Please let us know at this point if you have any question. At the top of the screen, there's an evaluation link. If you could click on that link and please provide us feedback for the presentation today. Also there's a file for downloading that we introduced before. There's the actual slides for the presentation today and the example superbill. We will be including these in the CBA@JSI website, cba.jsi.com under the billing resources as well.

Roberta, you see a question from Miriam: "Have you seen agencies that are doing billing that lose money? Are they not coding correctly?"

Roberta: Usually if you're billing for your services, you're not losing money. Whether people are coding correctly is a different question and usually, if you start billing, you create your own coding audits. You might do I within your organization or bring someone in to make sure that you are getting reimbursed for all the services that you can be reimbursed for [01:04:00].

Alexia: Thank you, Miriam. Any other questions? Have you worked with a CBO? If so, what were some of their challenges versus working with the Department of Health, hospitals, or clinics?

Roberta: I've worked with all of those organizations. They each have some of their own challenges. Community based organizations- yeah?

Alexia: I was going to speak to some of the challenges when moving towards billing for many of the community based organizations. It's not having a licensed provider that can bill for services, and so a model that's very typical for community based organizations to look at first is really partnering with another organization that does do billing and it could be a larger CBO that does billing, it could be a clinical provider and starting to get your feet wet in that way. Another good technique is sometimes actually hiring someone that does have ability to bill and start billing

with small things. For example, HIV testing or STD testing that are pretty basic and you could start doing a little bit of billing around that and also getting your feet wet to then expand on the services you provide and what you're billing for.

Roberta: I think that's an excellent response. Because you can get started in slow fashion. Most Medicaid programs will allow you to submit claims just via the web, so you don't need a whole billing system. Some people have created their own ledger sheets and they track their billing that way. You can start small steps [01:06:00], you can start with certain services and those services that are reimbursible. Perhaps there are some things that you need to continue to have great grant funding for but you might be able to diversify your revenue to a certain extent, and that takes a long time. I mean going from not billing at all to full billing is usually a two-year process and a significant commitment to any community based organization or clinical program.

Alexia: Thank you, Roberta.

Roberta: Ron ... here about can non-clinical ASO bill for HIV testing with no medical personnel? Probably not, unless you were to partner with some organization. Medical reimbursement really is based on the clinical model and so you might be able to partner … On your own, you would not be able to obtain those insurance contracts whether they be third-party or Medicaid without medical personnel. That's where partnering with an organization that does have medical personnel or a medical director who's willing to donate their services might be an option you could look at.

Alexia: Okay. I see Ron is typing. I also just … He says thanks. Okay. I also just sent the link to our website as well so you can check out some of those billing resources and do please join us on the 19th for asking more of these questions that are really pertinent. Thank you very much again for attending today. Thank you very much Roberta for such a great presentation and please do spend a minute filling out the evaluation for this session.

Roberta: Thank you very much [01:08:00] and thank you for having me.

Alexia: Thanks. Bye everyone.

Roberta: Bye.