HIV Coding and Billing for Public Health

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

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Executive Summary

The Human Immunodeficiency Virus (HIV) prevention landscape continues to evolve. HIV testing remains a critical activity supported by state, territorial, and local health departments (LHDs). Core HIV prevention and care activities led by local health departments depend on robust testing efforts to identify new infections and link people living with HIV (PLWH) to care. Public health services have traditionally been viewed as free, and a move toward billing and coding for these services requires a paradigm shift for both LHD staff and individuals seeking services. For LHDs, coding is a comprehensive approach and not isolated to just one clinical service. Most LHDs establish coding programs to include all of the clinical services that they provide.

Coding for HIV, STI and related services is an essential practice for programs that are preparing for billing third-party payers. Beginning to properly code for services is a critical step in improving revenue cycle management and developing sustainable systems.

Once the LHD has established a billing infrastructure, it can seek revenue across programs for reimbursable services such as HIV testing and counseling. Ultimately, state or local health departments should decide to bill after carefully assessing the communities they serve. If billing is the right decision for the LHD, dwindling public funds may be used for the most vulnerable populations. Despite challenges, LHDs have remained persistent and have developed creative ways to establish successful billing programs.

Billing for HIV services of insured individuals makes sense as a way to save money for federal, state, and local governments, assure proper stewardship of public funds and promote public and private payer participation.

Many of the children and adults seen by LHDs either already have insurance or are potentially eligible for insurance coverage for HIV services. Public programs including Medicaid, fund HIV services for individuals with limited financial means.

Finally, there are a number of laws and program requirements that require LHDs to code and bill for services. LHDs provide services and receive funding through public programs. Compliance with the various program requirements require LHDs to bill as appropriate. There are many factors that determine the ability of LHDs to bill for HIV services: local delivery and billing practices for a range of public health services, HIV services volume, and the public and commercial insurance markets.
This paper provides an overview for public health HIV billing, including billing Medicare, Medicaid, and private insurance; but these activities do not exist in isolation. They fit into a bigger picture of planning, budget and policy development, organizational objectives, grants, programs, and community priorities. Billing is one way to think and act more like a business. Billing allows health departments to identify and tap into existing sources of revenue to survive, even thrive, through tough economic times when people often need care most. Patients with private or commercial insurance pay premiums for health care benefits covered by their health plan.

In addition, this paper provides a general understanding of the coding guidelines for public health HIV services provided through local health departments (LHDs). This paper provides a high level review of:

- Medical code sets used for coding and billing HIV services.
- Format and conventions for ICD-10, CPT-4, and Evaluation and Management (E/M) codes.
- Basic coding guidelines by correctly referencing official coding guidelines to support accurate code assignment.
- Basic CPT coding steps by appropriately appending a CPT code with the correct modifier, as applicable.
- Documentation needed in order to code.

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.
HIV Coding Environment...Now

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

• A "code set" is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes.

Code sets for medical data are required for data elements in administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs. Medical data code sets that are used in the health care industry include coding systems for:

• Diseases
• Injuries
• Impairments
• Other health-related problems and their manifestations
• Causes of injury, disease, impairment, or other health-related problems
• Actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments, and substances, equipment, supplies, or other items used to perform these actions

Coding allows for:

• Standardizing documentation between LHDs.
  • The code for Streptococcal sore throat is the same in Illinois as it is in New York.
  • Having uniform data for efficient research and analysis, which government and health agencies use to track health trends.
  • If the LHD, for example, wants to analyze the prevalence of HIV, they can search for the number of recent HIV patients either by diagnoses and/or procedures.
• Administrations to look at the prevalence and effectiveness of treatment in the LHD clinic.

Local 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.

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 providing the service, and the setting in which the service is provided. Once a local health department has completed the applicable enrollment processes and is considered a participating provider (i.e., received the welcome letter), they can begin billing private/commercial insurance carriers, Medicare and Medicaid.
Local health departments must use codes sets when submitting claims for reimbursement. (HIPAA requirement). All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code and applicable CPT procedure code in order to be reimbursed.

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

A public health department or clinic may enter into various delivery models to partner for care continuity and billing services. Delivery models of how local health departments provide HIV services may vary:
- Local health department only.
- Local health department partnering with community-based organization(s) or individual physicians and other clinicians.
- Local health department partnering with laboratories.

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

The HIV services provided in a public health clinic may include:
- HIV Screening/Evaluation
- HIV Testing
- HIV Diagnosis
- HIV Monitoring
- HIV Counseling
- HIV Treatment

One of the most important criteria for coding and billing HIV services are the types of providers that work in the public health department or clinic. Furthermore, HIV clinics use a range of medical providers, including physicians, nurses, social workers, mental health providers, and others. However, private insurers may not recognize all of these as billable providers of services, given that the CPT codes used for billing center around services provided by a physician.

To obtain a contract with an insurer, clinics typically must have a physician or nurse practitioner who provides oversight of patient care. Allied health professionals may bill for certain services as if the supervising provider saw the patient only if (1) the patient is not being seen at the site for the first time and (2) supervising provider has provided standing orders. HIV providers often offer services outside of the clinic site – in the client’s home, at a health fair, or elsewhere in the community - where ordering providers may not be available to prescribe the service and oversee delivery.
In these cases, nurses may provide services using standing orders from the site Medical Director, Physician’s Assistant (PA), or Nurse Practitioner (NP), and the services can be billed under the LHD’s National Provider Identifier (NPI).

Other services in the home may be done by Peer Counselors assisting members with care coordination and can be covered under Community Health Worker services. Current Peer Counselors, who are not already certified as Community Health Workers, may want to go through the formal process of becoming certified before contracting with Health Plans to provide this service.

Nurses may also dispense medication without direct oversight, provided that the local Medical Director has established standing orders and protocols for the dispensing of that medication for that client. Health plans have different requirements for credentialing providers so you should check with the health plans you are planning to contract with to understand the potential for billing services with your current practitioner mix.

**Regulations/Acts Affecting Coding and Billing for HIV Services**

*Please note the following regulations affecting Coding and Billing for HIV services in the State of Illinois:*

**Medicaid**

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people, including disadvantaged children.

**Medicare**

All Medicare providers are required to file claims on behalf of the client per §1848(g)(4)(A) of the Social Security Act.

**Coding Documentation and Information Needed**

According to the Centers for Medicare and Medicaid Services (CMS), health record documentation is required to record pertinent facts, findings, and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. The health record chronologically documents the care of the patient and is an important element contributing to high quality care. Document every step you take. Remember, if it’s not documented in the record, it did not happen.

Documentation to have ready before beginning to code may include:

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

Documentation within the health record must clearly support the procedures, services, and supplies coded. Accuracy, completeness, and timely documentation are essential, and LHDs should have a policy that outlines these details. All services provided should be indicated on the Encounter Form/Superbill, whether reportable or billable. Encounter forms should reflect the individual staff member’s identification number assigned by the health department’s billing system.

The LHDs can be set up as roster billers and will not be paid for HIV services. Medicare is very strict on laboratory billing and requests that it must be done through a MD. Also, the majority of RCM clients do not keep medical records. They only utilize an encounter form.

“General principles” help ensure that medical record documentation for public health services is appropriate:
• The medical record should be complete and legible.
• The documentation of each patient encounter should include:
  • Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results.
  • Assessment, clinical impression or diagnosis.
  • Medical plan of care.
  • Date and legible signature with credentials (initials if included by agency policy) of the provider.
• If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
  • Past and present diagnoses should be accessible to the treating and/or consulting physician.
• Appropriate health risk factors should be identified.
• The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.
• The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
• Specific diagnosis codes should be reported when they are supported by:
  • Medical record documentation
• Clinical knowledge of the patient’s health condition
• Codes for signs/symptoms have acceptable, even necessary, uses.
• There are instances when signs/symptom codes are the best choice for accurately reflecting a health care encounter.
• If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
• Each health care encounter should be coded to the level of certainty known for that encounter.
• Use of symptom codes.
  • Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
• Use of a symptom code with a definitive diagnosis code.
  • Codes for signs and symptoms may be reported in addition to a related definitive diagnosis.
  • When the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.
  • The definitive diagnosis code should be sequenced before the symptom code.
    • Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
    • When a combination code that identifies both the definitive diagnosis and common symptoms of that diagnosis, do not code the symptom.
• For HIV Infections:
  • Code only confirmed cases of HIV infection/illness.
  • Confirmation does not require documentation of positive serology or culture for HIV.
    • Provider’s statement that client is HIV positive, or has an HIV-related illness, is sufficient.
  • For HIV testing - Z11.4, Encounter for screening for HIV.
  • Use additional codes for any associated high risk behavior (e.g., Z72.5 -, High risk sexual behavior) or for any counseling provided (Z71.7).
• HIV+ not the same as AIDS/HIV infection.
  • Never report them together.
  • HIV+ and inconclusive HIV, not the same.
  • Never report them together in the same encounter
  • When documentation states HIV-2:
    • Principal diagnosis = HIV-1
    • Secondary diagnosis = HIV-2

The list below summarizes some of the services for which public health clinics and labs can code and bill third party payers.
• Evaluation and Management Services
• Risk assessment counseling
• HIV counseling and testing
• Linkage to Care & Patient Navigation/ Care Coordination/ Case Management
• Screening and treatment for:
  • HIV/AIDS

Hence, the coders at the local health department or clinic would need to code these as applicable to services rendered.

Case management codes are not recognized by Medicare but other insurers may cover them, so it is important to check with the individual insurers. The Ryan White Funded Support Service may pay for case management codes (medical, nonmedical, and family centered).

**Medical Code Sets Used for HIV Coding**

All services provided to the patient/client during a visit are reported using a coding system. There are four commonly used types of codes: CPT® codes, diagnosis codes, modifiers and Healthcare Common Procedure Coding System (HCPCS) codes. The codes used to explain procedures performed are called CPT® codes.

The Current Procedural Terminology (CPT®) codes were developed and are maintained by the American Medical Association (AMA). They are alphanumeric codes that medical coders and billers use to report health care services and procedures to payers for reimbursement. There are two types of CPT® codes used by providers: evaluation and management (E/M) codes and procedure codes.

Evaluation and management codes are used to describe the general patient visit. LHDs may reference E/M codes as office visit codes. There are several levels of evaluation and management codes to designate the time spent and level of decision-making required. Evaluation and management codes are often accompanied by the other classification of CPT® code known as a procedure code. Procedure codes describe specific services that are performed in addition to evaluation and management codes.

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 local health department should be compensated. Diagnosis codes are used to describe the primary complaint of the patient or why the patient is being seen. The codes can range from sore throat to chest pain. There is a diagnosis code for various medical problems. HCPCS codes use alpha and numeric characters to describe some drugs and other supplies.

**HIV Coding: ICD-10-CM Guidelines**

ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of
diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion that allows for:

- Easy storage, retrieval and analysis of health information for evidenced-based decision-making.
- Sharing and comparing health information between hospitals, regions, settings and countries.
- Data comparisons in the same location across different time periods.

The guidelines are located specifically in section I.C.1 under Chapter 1, Certain Infectious and Parasitic Diseases (I.C.1.a.1 – I.C.1.a.2.h). According to the diagnostic coding and reporting guidelines for outpatient services (IV.H), uncertain diagnoses should not be coded, but there are three times in the chapter-specific guidelines, this guideline is repeated.

The first time is in the guidelines for HIV/AIDS where it states to code only confirmed cases of HIV infection/illness (I.C.1.a.1). It further states that confirmation does not require documentation of positive serology or culture for HIV, but that the provider's diagnostic statement that the patient is HIV-positive or has an HIV-related condition.

If a patient is admitted for an HIV-related condition, the first-listed diagnosis should be B20 followed by additional diagnosis codes for all reported HIV-related conditions (I.C.1.a.2.a). If patient/client is HIV-positive and asymptomatic, do not code from Chapter 1.

The codes that may be assigned for HIV in ICD-10-CM are as follows:
B20 Human immunodeficiency virus (HIV) disease (only use with confirmed cases)
Z21 Asymptomatic human immunodeficiency virus (HIV) infection status (only use with confirmed cases)
Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus (HIV)
Z71.7 Human immunodeficiency virus (HIV) counseling
Z71.4 Encounter for screening for human immunodeficiency virus (HIV)
R75 Inconclusive laboratory evidence of human immunodeficiency virus (HIV) (only use with confirmed cases)

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

ICD-10-CM B20 is grouped within Diagnostic Related Group(s) (MS-DRG v32.0):
969 HIV with extensive o.r. procedure with mcc
970 HIV with extensive o.r. procedure without mcc
974 HIV with major related condition with mcc
975 HIV with major related condition with cc
976 HIV with major related condition without cc/mcc
HIV with or without other related condition

Do not use the code for AIDS (B20) or HIV+ (Z21) when the record/chart states:

- Suspected
- Suspicion of
- Possible
- Likely
- Rule out
- Questionable
- Consistent with
- Presumed to be
- Appears

Key Steps for Coding Diagnoses
The Diagnosis code set will be the ICD-10-CM code set. Some key coding steps may include:

Step 1: Find the condition in the alphabetic index. Begin the process by looking for the main term in the alphabetic index. After locating the term, review the sub terms to find the most specific code available. Instructional notes in this section will help guide the reader with information such as “see,” “see also,” “with,” “without,” “due to,” and “code by site.”

Step 2: Verify the code and identify the highest specificity. The second step in the process is verifying the code in the tabular index. This is the alphanumeric listing which organizes codes by disease and injury. Additional detail is found here to create the most complete code. The tabular index identifies severity (intermittent, mild persistent, moderate persistent, or severe persistent) as well as complications. The tabular index also contains information identifying the length of a code; this is important since a code is anywhere from three to seven characters long. This index includes additional information such as “Excludes 1” and “Excludes 2” status. The exclude notes identify codes that can never be reported together (Excludes 1) and codes that can never be reported at the same time (Excludes 2).

Step 3: Review the chapter-specific coding guidelines. The final step in locating a code is a review of the chapter-specific coding guidelines found before the alphabetic index of the ICD-10 manual. This index includes guidelines for specific diagnoses or conditions. Some of the more complex diagnosis codes can be found here including HIV. Without consulting this section, important sequencing guidelines would be missed.

HIV Coding: CPT-4 Guidelines
Procedure codes are also known as CPT-4 (Current Procedural Terminology, 4th Edition), and occasionally HCPCS (Healthcare Common Procedure Coding System, Level II).

- They are used to tell insurance companies what kind of procedure or service was performed on the patient.
• They also sometimes denote pharmacy and supply items, as well as capture visit times.

• Procedure codes are 5-character numbers.

• True CPT-4 codes are 5 numbers, whereas HCPCS codes are a letter and 4 numbers.

• Procedure codes must match up with **diagnosis codes** in order to get claims paid.

• Use 99201–99205 for “new” patients.

• Use 99211–99215 for “established” patients.

Current Procedural Terminology (CPT®) codes were developed and are maintained by the American Medical Association (AMA). They are alphanumeric codes that medical coders and billers use to report health care services and procedures to payers for reimbursement. Please note that 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. 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.

In addition, the main Evaluation and Management (E/M) code that a Registered Nurse (RN) can bill independently is 99211, which is essentially defined as a low-level outpatient visit that may not require the presence of a physician to perform or supervise. Evaluation and Management codes typically include a patient history, physical exam, and medical decision making. Common uses for a 99211 in a public health department that provides HIV services are: HIV screening and stand-alone HIV Counseling and Testing. These encounters must be face-to-face. There are certain minimal documentation requirements for use of 99211. Since 99211 is an E/M code, here are the requirements in order to meet medical necessity for use of the code:

• There must be a face-to-face encounter

• Nature of the presenting problem with a diagnosis from prior visit with a clinician

• Brief history of the problem

• Documentation of vital signs (Sole reason for visit should not be Blood Pressure check or Blood Draw. You can't check vital signs such as blood pressure or temperature across the board on patients who come in for a blood draw or other minor service, just so you can bill 99211. CMS warns you must document the medical necessity for the check. Example: You may use 99211 for a blood pressure check, but there must be a doctor's order that this must be done. You must have a need for doing it. A diagnosis is needed. The nurse should say 'as per doctor's order' the blood pressure was checked.)

• Plan of care

• Date/signature of the nurse or other provider
Listed below are services that cannot be billed under 99211:

- Administering routine medications by physician or staff whether or not an injection or infusion code is submitted separately on the claim.
- Checking blood pressure when the information obtained does not lead to management of a condition or illness.
- Drawing blood for laboratory analysis or for a complete blood count panel, or when performing other diagnostic tests whether or not a claim for the venipuncture or other diagnostic study test is submitted separately.
- Faxing medical records.
- Making telephone calls to patients to report lab results and reschedule patient procedures.
- Performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed, or payment is bundled with reimbursement for another service) whether or not the procedure code is submitted on the claim separately.
- Recording lab results in medical records.
- Reporting vaccines.
- Writing prescriptions (new or refill) when no other evaluation and management is needed or performed.

The preventive medicine codes are intended to be used in the absence of an established diagnosis. 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. These codes can only be billed by a Qualified Health Professional. They cannot be billed by a RN.

- 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

Bill laboratory codes for laboratory tests done on site.

- CPT Code 36415 = one venipuncture collection fee when the lab work is sent out to an outside lab regardless of the number of specimens drawn.
  - HIV Blood Draw

**HIV Coding: Evaluation and Management (E/M) Guidelines**

Evaluation and Management code, or visit code, denotes the time, place of service, or type of patient the LHD provider has seen. It can also be a lab test, which is considered a procedure even though sometimes the patient may not have been at the facility that took the sample.
Two sets of E/M guidelines are available:


Use these guidelines to learn more about the specific steps for determining the levels for the key components and their respective elements. Neither set of guidelines is better. The LHD may use either set of guidelines to determine the appropriate code level for the E&M services provided. For each separate E&M service, you must use only one set of E&M guidelines throughout the code determination process. Mixing or combining the two sets of guidelines for a single E&M encounter is not acceptable.

**HIV Coding: Modifier Guidelines**

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. In response to the ACA, CPT® developed modifier 33 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). Use modifier 33 on the CPT code for HIV screening. This informs the payer that the service is a service recommended by the USPSTF.

HIV screening has an “A” rating from the United States Preventive Services Task Force (USPSTF.) It is a covered service by Medicare, Medicaid and commercial insurance companies. Please make sure to check with the payers on their limitations for number of HIV screenings covered per year. 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 screened annually. Also, United Healthcare, in its National Coverage Determination N210.7, gives the frequency limit to one annual screening except for pregnant beneficiaries.

For patients with commercial policies, it should ensure 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. 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.

It is important to note that modifier 33 is not recognized by most payers and is only used when performing a test or procedure for preventative purposes only if the description of that CPT code is not already categorized as preventative. Illinois Medicaid, which is the largest payer for the LHDs, does not recognize this modifier.
Maintenance of HIV Coding Process
A HIV screening test may be denied because:

- The test was done in a setting in which a bundled payment was negotiated for the service, and the screening is not included in the negotiated rate.
- The patient is already diagnosed with the condition, and no longer needs to be screened for the illness.
- An incorrect diagnosis is reported.
- The payer has established frequency limits for the service.
- Modifier 33 was not appended to the CPT® or HCPCS code. Review payer contract/agreements and reimbursement schedules that contain codes to avoid denials.

So, in summary, proper HIV documentation and coding could support compliant HIV billing practices. Make HIV coding more efficient:

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

Once the LHD has established a billing infrastructure, it can seek revenue across programs for reimbursable services such as HIV testing and counseling. Ultimately, state or local health departments should decide to bill after carefully assessing the communities they serve. If billing is the right decision for the LHD, dwindling public funds may be used for the most vulnerable populations. Despite challenges, LHDs have remained persistent and have developed creative ways to establish successful billing programs.

HIV Billing Environment...Now

Local 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. 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 providing the service, and the setting in which the service is provided. Once a local health department has completed the applicable enrollment processes and is considered a participating provider (i.e., received the welcome letter), they can begin billing private/commercial insurance carriers, Medicare and Medicaid.

HIV testing remains a critical health department activity to eliminate new HIV infections in the United States.

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

The HIV services that are provided in a public health clinic may include:

- HIV Screening/Evaluation
- HIV Testing
- HIV Diagnosis
- HIV Monitoring
- HIV Counseling
- HIV Treatment
One of the most important criteria for billing HIV services are the types of providers that work in the public health department or clinic. Furthermore, HIV clinics use a range of medical providers, including physicians, nurses, social workers, mental health providers, and others. However, private insurers may not recognize all of these as billable providers of services, given that the CPT codes used for billing center around services provided by a physician.

To obtain a contract with an insurer, clinics typically must have a physician or nurse practitioner who provides oversight of patient care. Allied health professionals may bill for certain services as if the supervising provider saw the patient only if (1) the patient is not being seen at the site for the first time and (2) supervising provider has provided standing orders. HIV providers often offer services outside of the clinic site – in the client’s home, at a health fair, or elsewhere in the community - where ordering providers may not be available to prescribe the service and oversee delivery.

In these cases, nurses may provide services using standing orders from the site Medical Director, Physician’s Assistant (PA), or Nurse Practitioner (NP), and the services can be billed under the LHD’s National Provider Identifier (NPI). Other services in the home may be done by Peer Counselors assisting members with care coordination and can be covered under Community Health Worker services. Current Peer Counselors, who are not already certified as Community Health Workers, may want to go through the formal process of becoming certified before contracting with Health Plans to provide this service.

Nurses may also dispense medication without direct oversight, provided that the local Medical Director has established standing orders and protocols for the dispensing of that medication for that client. Health plans have different requirements for credentialing providers so you should check with the health plans you are planning to contract with to understand the potential for billing services with your current practitioner mix.

**Billing Information Needed**

It is expected that local health departments (LHDs) perform certain functions related to third-party billing. Health departments with low HIV services volume and no other potential third-party billing may implement these practices and choose not to implement any other billing activities. The basic requirements are detailed below and ensure that compliance with state and federal programs such as the General Public Health Work Program and public third-party payer requirements is maintained.

1. **Collect insurance information:** When a patient schedules an appointment or walks in for an appointment, all LHDs should ask the patient or guardian for any third-party coverage information. LHDs need third-party payer information collected at every encounter to
determine eligibility and provide patients with the necessary documentation to pursue reimbursement of their out-of-pocket medical expense. It is expected that LHDs will use the billing data repository function to assist in this if they do not have another information system with third-party payer information collection capacity.

2. **Determine Payer Mix:** All LHDs should compile insurance information and determine their payer mix for HIV services, identifying the major potential sources for reimbursement. LHDs can use this information to determine the most cost-effective billing approach. This information also indicates which managed care contracts to pursue.

3. **Establish and Implement an Out-of-Pocket Patient Fee Process:** In accordance with Public Health Law Articles, LHDs must bill patients for administration fees as appropriate. LHDs should have approved fees and sliding-fee scales.

4. **Encourage Insurance Enrollment:** LHDs should utilize local facilitated enrollment counselors to promote access to care among those patients eligible for public programs.

5. **Submit Claims to Public Insurance Programs:** All public health clinics must claim reimbursement for the services they provide for publicly insured individuals. All LHD clinics must be enrolled as Medicaid and Medicare providers and should verify eligibility and conditions of coverage including enrollment in managed care for the date HIV services are provided.

There are specific identifiers used for billing HIV services. These can include:

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

The taxonomy code describes the type of services and area of specialty for the provider. There is a special coding system. There is a taxonomy code lookup on the CMS website. LHDs may need its provider’s taxpayer identification number (TIN). It is also commonly referred to as the Employer Identification Number (EIN). LHDs may need it to get reimbursed by payers. If the provider doesn’t have one, visit the IRS website to apply.

A further explanation of the National Provider Identifier is warranted as this is a HIPAA requirement. It is 10 digits long. If you are an individual, you would select location type 1. Most public health clinics would select type 2 location. The NPI is issued once and doesn’t expire for that clinic. If the clinic closes and reopens, the same NPI would be issued. If the EIN changes and location changes, then a new NPI would be issued.

Various public health clinics and labs may be able to bill third-party payers for these billable service types:

- Evaluation and Management Services
- Risk assessment counseling
- HIV counseling and testing
- Linkage to Care & Patient Navigation/Care Coordination/Case Management
- Oral health
- HIV Screening and treatment
There may be some non-billable service types. Case management codes are not recognized by Medicare but other insurers may cover them. So, it is important to check with the individual insurers. The Ryan White Funded Support Service may pay for case management codes (medical, nonmedical, and family centered).

**Billing Information Lifecycle**

The revenue cycle and foundational aspects of successful billing practice include information systems, relationships with third-party payers, and personnel resources.

Revenue cycle management encompasses the entire process of managing claims, payment, and revenue generation. The following are elements of the revenue cycle based around the patient’s visit to your site.

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

If the LHD has clients that make appointments in advance, see the pre-visit information. For those that largely see walk-in clients, skip to the visit section. Information collected before the visit helps to ensure that the clinic or health department has the information it needs to submit a bill. Information collected from patients should include:

- Contact information
- Demographic information
- Insurance plan and membership number (to verify eligibility and benefits)
- Reason for visit

Using the insurance information captured prior to the visit, staff would contact the insurance carrier to determine eligibility and seek pre-authorization for specific visits/providers, as needed. The staff could also seek information about any charges the patient may be responsible for, so that the patient can be informed. LHDs should utilize online insurance portals first as it could save time from having to call. In regards to authorization, the services provided at the LHDs do not require authorization. This would be for a physician or specialist office.
Prior to the visit, it is preferable to communicate to the patient the payment process and the service prices, depending on their coverage. This way, patients will be more prepared to pay any fees or participate in insurance enrollment once they arrive for the visit. Patients should also be advised to bring their insurance card to the visit to assist in eligibility verification.

As the patient checks-in, you would ask them to confirm their insurance and contact information and make copies of insurance cards. You would also have the client sign any forms, for example authorizing release of information to the insurer, privacy policies and practices and the policy outlining a client’s financial obligations. Staff would then verify the billing information to ensure the information is accurate at the time of service. To verify insurance coverage, it will help to gather standardized information from each client. Assigned staff would then use this information to contact the relevant insurer to confirm the client is enrolled. All charges and payments should be reconciled and posted to the appropriate accounts at the end of each day.

After the visit, the services and procedures delivered will be converted into CPT, ICD-10 and HCPCS codes and a claim is submitted to the payers.

Also, the revenue cycle is comprised of the financial processes associated with each patient visit, from registration to billing, receipt of reimbursement, and closing each fee balance. The processes are categorized into three parts: front-end processes, intermediate processes and back-end processes.

**Front-End Processes** include scheduling, patient registration, insurance determination and verification, collection of co-pays, deductibles or self-pay amounts and sliding-fee application. The information gathered at this stage of the process is critical to ensure that insurance claims are not denied for reasons such as invalid insurance coverage, service authorization not obtained or service not covered under the member’s benefit plan.

**Intermediate Processes** include the capture of service information in an electronic or manual encounter form. This includes procedure and diagnosis codes as well as other data elements required for billing third-party payers and data entry. Correct coding is important for submission of accurate reimbursement claims.

**Back-End Processes** consist of claims creation and submission, posting payments to open accounts, claims follow-up and patient billing statements. In addition, back-end processes include those steps in account reconciliation and closure of each fee balance.

LHDs need internal reporting tools and control mechanisms in place to ensure all claims are properly adjudicated and routine reports are created to monitor billing processes and outcomes. The **foundation** of successful billing includes three components:
1. **Information System Capacity**: LHDs need an information system or service that can provide:
   - Single-point patient data entry
   - Useful for multiple clinical service areas within a LHD
- Efficient data transmission
- Electronic claim submission
- Availability of service data for billing functions
- Account reconciliation
- Financial and statistical reporting capabilities
- Data import and export capabilities

2. Third-party relationships: To obtain reimbursement for HIV services provided to enrolled patients, LHDs need to develop relationships with insurance plans, including:
   - Network agreements with insurance plans
   - Credentialing of LHD practitioners with insurance plans so that LHDs can be reimbursed as network providers
   - Clearinghouse Agreements to enable streamlined LHD communication with payers. These services may be free or require contract agreements.

3. Workforce Capacity and Capability: LHDs need sufficient personnel resources to:
   - Handle scheduling and registration
   - Submit claims, post payments and address outstanding accounts
   - Handle electronic claims, enrollment process and submit paperwork for electronic funds transfer (EFT) deposits from payers
   - Manage the health plan contracting and credentialing effort
   - Handle IT support for software implementation, maintenance and troubleshooting

Billing Policies and Procedures

It is important for LHDs to develop policies and procedures relating to the revenue cycle, billing process, and billing requirements. Here is high-level snapshot of the billing cycle:

![Billing Cycle Diagram]

These duties can be spread out among different staff throughout the clinic. Written policies and procedures are vital to the success of billing and should be carefully developed to include all aspects of the process. Billing staff should be well-trained on the policies and procedures and have the ability to refer to them at any time to aid in performing their assigned tasks.
policies and procedures should be kept up-to-date at all times. The LHDs should update the policies and procedures immediately when changes in workflows and systems occur.

Provider Enrollment & Credentialing
Before a health department can begin to bill and receive reimbursement from either a public or private insurance payer for HIV services, the health department’s medical staff must be credentialed as participating providers based on the payer’s accepted standards or an accepted standard within the state. Healthcare credentialing is “the process of verifying education, training, and proven skills of healthcare practitioners.” All healthcare providers must be evaluated through a credentialing process in order to successfully bill third-party payers, with limited exception. The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that the “Health Care Professional Credentialing and Business Data Gathering Form” be completed per provider.

Eligibility & Verification
Before rendering service(s) to a patient, LHDs will need to determine what program and/or insurance coverage will reimburse for the HIV services. There are two verifications to be addressed:

Eligibility
- Is the patient eligible for the program/health plan for the date of service?
- Is the patient eligible under more than one program/health plan?
- Is your LHD considered a participating provider for this program/health plan?

Coverage
- What is the coverage, or benefits, that will be provided by the program/health plan?
- Are HIV services covered under the medical portion of a program/health plan, or are some covered under a separate plan?
- Will a deductible, copayment or coinsurance be applied to the HIV services?

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client’s demographics, insurance coverage, and services requested. New patients should complete a form at their first visit. Established patients should complete one if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important steps that should be taken with every client at every visit:
- Copy the client’s primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and Exclusions
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of Waiver for non-covered services and payment options
It is the provider’s responsibility to verify coverage before services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the patient after services have been provided. “Active” coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client’s individual insurance plan/exclusions to identify “Non-Covered” services.

In order to charge clients for non-covered services, a Waiver for Non-Covered Services with the following information must be provided to the patient:
- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

**Coordination of Benefits**

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

By federal law, Medicaid is the “payer of last resort” in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. A third-party resource is an individual, entity, or program that is or may be liable to pay for all or part of the expenses for medical care provided to a Medicaid client. COB regulations require that all health plans coordinate benefits to eliminate duplication of payment and ensure clients receive the maximum benefits they are entitled to. Medicaid will consider payment of a claim only after all other third-party resources have been exhausted.

When a client has other coverage that is potentially liable for payment of a claim, a COB claim is required prior to billing Medicaid. A COB claim submitted to Medicaid may be processed in one of two ways:
- Cost-avoid: A Provider must bill the primary payer before billing Medicaid. Medicaid will pay the claim once the primary payer processing information is included on the claim.
- Pay-and-chase: Medicaid will pay for the services and then attempt to recover from the liable third-party. If Medicaid pays for these services, the Provider cannot bill the third-party payer.

When the liability of a third-party cannot be established or is not available to pay for the client’s services within an applicable timeframe, Medicaid may reimburse the provider for covered services in accordance with standard reimbursement procedures.
Third-Party Liability Non-covered List (Blanket Denial)
When a service is not covered by a beneficiary’s primary insurance plan, a blanket denial letter can be requested from the insurance carrier. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. Providers could retain this statement on file to be used as proof of denial for one year. The non-covered status must be reconfirmed and a new letter obtained at the end of one year.

A Medicare crossover claim is any claim that is approved by Medicare and then sent to Medicaid for consideration of payment not to exceed the sum of the Medicare deductible, copay, or coinsurance. The claim must be approved by Medicare in order to be considered a crossover claim. “Approved” does not mean paid; sometimes the charges approved by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare. It is important to remember that claims that are denied by Medicare are not crossover claims. If a member is a Qualified Medicare Beneficiary (QMB) and Medicare denies the claim, do not bill Medicaid.

The receipt of a crossover claim by Medicaid does not mean that Medicaid will make a payment on the claim. If Medicaid approves the claim, a payment of the sum of the coinsurance and deductible may be made. If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay anything on the claim, but the claim will still be a paid Medicaid claim.

The following suggestions may assist LHDs in reducing payment delays attributed to COB-related problems:
- Ask patients about secondary insurance coverage. Collect and confirm primary and secondary insurance information at each visit.
- Know what plans and payers need to pay claims. Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.
- Understand Primary & Secondary Payers. The following rules are used to determine the primary and secondary payer:
  - The payer covering the patient as a subscriber will be the primary payer.
  - If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule. However, the birthday rule is not always followed with the roll out of the ACA and when the parents of the dependent are divorced.

Contracting with Payers
In order to bill most payers, the LHD must be contracted with the payer. It is best to contact
each payer and ask how claims will be processed with and without a contract. However, it is not
up to the payer to decide how out of network (OON) claims will be paid. It is actually up to the
individual patient policy and if they cover OON benefits on the plan. Also, an LHD may
contract with a network. This allows the LHD to bill multiple payers under one contract. One
way to facilitate billing by public health departments is to require insurance companies to treat
such clinics as in-network providers.

Similarly, “any willing provider” laws provide a unique opportunity for states to integrate
service providers into the existing third-party reimbursement system. “Any willing provider”
laws require that insurers, managed care organizations, and other health plans give all
physicians (and sometimes other providers) membership on their preferred provider lists if
those physicians are willing to meet the terms and conditions for membership and if they offer
the type of medical services that the insurers or managed care organizations offer their
subscribers.

To be considered as an in-network provider, health departments identified as a “facility” must
enter into a contractual agreement with third-party payers to provide a limited range of
services to covered members. The Provider Agreement also includes specific guidance on the
responsibilities, reimbursement rates and claim submission processes that both parties must
adhere to.

Claims Submission & Resubmission

Claim Forms/Electronic Billing
The billing process requires the completion of various electronic forms or paper documents.
Many billing models allow for the documentation to be created and stored in an electronic
format. The terms superbill, charge ticket and encounter forms are generally interchangeable.
This is the document used to record the services being provided to clients. Typically, it is a log
sheet where the health care provider checks a series of boxes to indicate the services provided
to the patient and an explanation of why these services were provided. If the LHD is using an
electronic health record (EHR) system, the superbill document will be located on the computer
and will be completed by the health care provider on the computer. Without an EHR, the same
tasks are accomplished manually and then the data is manually entered into the billing
model by the billing staff.

When health departments bill third-party payers, they typically require accurate completion of
a claim form that provides information about the patient’s demographics, services provided,
and type of provider responsible for the services (e.g., physician, nurse, or therapist). The claim
form conveys this information as diagnostic codes and procedure codes. Third-party payers rely
on the existing system of diagnosis and procedure codes to administratively and financially
reimburse for services. Proper use of the diagnosis and procedural codes, as well as accurate
coding, is essential for claims submitted to third-party payers.

The Health Insurance Portability and Accountability Act (HIPAA) requires health care providers
to obtain a National Provider Identifier (NPI) for use in standard HIPAA transactions including
insurance billing. Providers obtain a NPI from the Centers for Medicare and Medicaid Services (CMS). The NPI number never expires and will not change as the result of job or relocation. It is intended as a unique identifier for all health plans to utilize. NPI numbers are essential to most insurance enrollment and billing processes.

The healthcare services coding system is regulated by the Centers for Medicare and Medicaid Services and is recognized under the Health Insurance Portability and Accountability Act. The Current Procedural Terminology (CPT) coding system is maintained and copyrighted by the American Medical Association and revised each year in October. The CPT codes describe the medical, surgical, and diagnostic services provided.

The submission and resubmission of claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange (EDI) to third-party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form or HFS 2360 form correctly.

The CMS-1500 form is the standard for submitting health insurance claims on paper to private insurers and Medicare. Form HFS 2360 is used for submission to Medicaid. Instructions on completing the forms can be found online with various insurance carriers and the Centers for Medicare & Medicaid Services (CMS). Photocopies of the CMS-1500 form cannot be used for submission of claims, since copies may not accurately replicate the scale and OCR color of the form.

After the insurance carrier receives and processes a completed CMS-1500 form, it sends the LHD a status report called an Explanation of Benefits (EOB). There is no standard format for how insurance companies report payment information on their EOBs. EOBs typically include a listing of the services provided, the amount billed, any insurance payments and the amount due from the patient. The EOB is sometimes accompanied by an insurance benefits check.

Medicare supplies a similar report, the Explanation of Medicare Benefits (EOMB), and Medicaid sends Remittance Advices (RAs, also called 835s). These forms all accomplish the same purpose—to explain the status of a claim. More specifically, an EOB, EOMB or RA is likely to include:

**Negotiated or Allowed Amount:**
The in-network rate that was negotiated for the service. Otherwise this will be the recognized amount under the member’s plan.

**Paid Amount:**
The actual amount paid by the insurer for the item or service, after coinsurance and deductibles are factored in.

**Copay/Co-insurance Amount:**
Identifies the amount the patient owes as a copayment/co-insurance for this service.

**Deductible Amount:**
This is the amount of the patient deductible that applies to the “submitted charges” or the “negotiated or allowed amount.”

**Pending or Not Payable:**
Portions of the claim amount may be pending or is denied.

**See Remarks or Message Codes:**
These explain the reason(s) that an amount is pended or denied.

Unfortunately, some of the “remarks” or “message codes” received may likely indicate denial of payment. Denials occur for many reasons. Some denied claims will ultimately be paid if they are rebilled. Others will not. Some common reasons LHDs are denied payment are:

- no coverage on date of service
- not a contracted provider
- not a covered service
- coding errors
- applied to deductible and/or co-insurance

A denial doesn’t necessarily translate into a write off. The key is to understand the reason for the denial, and to correct and resubmit the claim as appropriate. Once the LHD becomes accustomed to filing claims, interpreting denial codes may not be that difficult and will generally know what to expect of each insurance company. If an LHD receives a denial from a contracted carrier, follow up is necessary.

As more and more importance is put on electronically submitting claims due to other Federal initiatives, many electronic billing processes evolved to utilize a clearinghouse. Rather than submitting claims to each payer separately—including private insurance, Medicare and Medicaid—the LHD can transmit all claims to the clearinghouse, which checks them for errors and efficiently and securely transmits them to the appropriate carrier for payment.

**Claim Requirements**
LHDs must take all reasonable measures to determine a third-party payer’s liability for covered services prior to filing a Medicaid claim. If a third-party insurance plan denies or pays part of the applicable reimbursement rate:

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental plan for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.
• When a carrier issues a blanket denial letter for a non-covered procedure code, the provider should include a copy of the denial.
• FFS Medicaid covers 5 types of HIV visits, 3 have to do with testing (certain visits can be billed same day).
• Managed Care Organizations (MCOs) and commercial (private) plans have an entirely separate set of codes to use but similarly, may allow for same day billing of these visits. MCO plans have the same billing guidelines as Medicaid, which is completely different then commercial insurance.

For MCOs, failure to file a claim within the contracted timely filing after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim. If a provider believes a negative adjustment is appropriate, the provider may adjust and resubmit a claim.

A third-party payer may deny part or all of a claim for the following reasons: 1) The services are not covered; 2) The client was not eligible on the date of service; 3) The provider failed to obtain prior approval or precertification for the required services; or 4) The services provided have been determined to be medically unnecessary.

Filing Time Limits
Every health insurance company has its own policy on timely filing. Visit each payer site or contact a representative for details and updated information. Know time limitations for filing claims. Time limits can vary with the company. Private health insurance companies set their own time limits for filing. When contracting with health plans, LHDs may want to negotiate billing time limitations so they fit well with the LHD’s business schedule.

Appeals Process
Every health insurance company has a grievance and appeal procedure defined in its policy. LHDs can appeal a third-party payer’s decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer’s website for instructions on how to appeal a claim. The third-party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

Medicaid Denial Issues
When facing denials, there are multiple reasons that could be causing the issue. The first step in dealing with a denial is to review the denial code and determine what is causing the denial. Review prior claims or reach out for assistance from other billers.
## Appendices

### Acronyms

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<td>American Medical Association</td>
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<td>BCBS</td>
<td>Blue Cross Blue Shield</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>COB</td>
<td>Coordination of Benefits</td>
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<td>COBRA</td>
<td>Consolidate Omnibus Budget Reconciliation Act</td>
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<td>DX</td>
<td>Diagnosis Code (ICD-9 or ICD-10)</td>
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<td>E/M</td>
<td>Evaluation and Management</td>
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<td>Electronic Medical Record</td>
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<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnostic, and Treatment</td>
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<td>ERA</td>
<td>Electronic Remittance Advice</td>
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<td>ERISA</td>
<td>Employee Retirement Income Security Act of 1974</td>
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<td>FFS</td>
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<td>Group Health Plan</td>
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<td>Healthcare Common Procedure Coding System</td>
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<td>Health Savings Account</td>
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<td>ICD-10</td>
<td>International Classification of Diseases, 10th edition</td>
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<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MSP</td>
<td>Medicare Secondary Payer</td>
</tr>
<tr>
<td>N/C</td>
<td>Non-Covered Charge</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>NEC</td>
<td>Not Elsewhere Classifiable</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>NOS</td>
<td>Not Otherwise Classifiable</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OI</td>
<td>Other insurance</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>PEC</td>
<td>Pre-existing Condition</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information</td>
</tr>
<tr>
<td>POS</td>
<td>Place of Service</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance Advice</td>
</tr>
<tr>
<td>RVU</td>
<td>Relative Value Unit</td>
</tr>
<tr>
<td>SOF</td>
<td>Signature on File</td>
</tr>
<tr>
<td>TAR</td>
<td>Treatment Authorization Request</td>
</tr>
<tr>
<td>TIN</td>
<td>Tax Identification Number</td>
</tr>
<tr>
<td>TOS</td>
<td>Type of Service</td>
</tr>
<tr>
<td>TPA</td>
<td>Third-Party Administrator</td>
</tr>
<tr>
<td>TPL</td>
<td>Third-Party Liability</td>
</tr>
<tr>
<td>UB</td>
<td>Uniform Billing</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
</tbody>
</table>
Definitions

ACA – Affordable Care Act. Also referred to as “ObamaCare”. A federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable.

Accept Assignment – When a provider accepts as “full-payment” the amount paid on a claim by the insurance company, excluding the coinsurance, deductible or co-pay due from the patient.

Adjusted Claim – A claim that has been corrected, due to an error during submission or payment, which results in a credit or payment to the provider.

Allowed Amount – The reimbursement rate that the insurance company will pay for a procedure.

AMA - American Medical Association. The AMA is the largest association of doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

Aging - One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing softwares have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

Appeal - When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider’s web site.

Applied to Deductible - You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

Assignment of Benefits - Insurance payments that are paid to the doctor or hospital for a patient’s treatment.

Beneficiary - Person or persons covered by the health insurance plan.

Blue Cross Blue Shield (BCBS) - An organization of affiliated insurance companies, independent of the association (and each other), that offer insurance plans within local regions under one or both of the association's brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit. BCBS sometimes acts as administrators of Medicare in many states or regions.

Business Associate - The HIPAA definition of Business Associate has broad applicability and includes, other than a health care provider's employees, "partners" that may provide legal, actuarial, accounting, consulting, data aggregation, management, administration or financial services wherein the services require the disclosure of individually identifiable health information.

Capitation - A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients’ health care services. This payment is not affected by the type or number of services provided.

Carrier – The insurance company or “carrier” the patient has a contract with to provide health insurance.

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services. Recently renamed
TRICARE. This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors.

**Charity Care/Sliding Scale** - When medical care is provided at no cost, or at reduced cost, to a patient that cannot afford to pay.

**Clean Claim** - Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

**Clearinghouse** - This is a service that transmits claims to insurance carriers. Prior to submitting claims, the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPAA standards.

**CMS** - Centers for Medicaid and Medicare Services. Federal agency which administers Medicare, Medicaid, HIPAA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration).

**CMS 1500** - Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on CMS-1500s. The form is distinguished by its red ink.

**Coding** - Medical billing coding involves taking the doctor’s notes from a patient visit and translating them into the proper ICD-10 code for diagnosis and CPT codes for treatment.

**COBRA Insurance** - This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, it is typically more expensive than the insurance cost when employed, but does benefit from the savings of being part of a group plan. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and, under certain conditions, can extend up to 36 months.

**Co-Insurance** - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example, the insurance carrier pays 80% and the patient pays 20%.

**Contractual Adjustment** - The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

**Coordination of Benefits** - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

**Co-Pay** - Amount paid by patient at each visit as defined by the insured plan.

**CPT Code** - Current Procedural Terminology. This is a 5-digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding ICD-10 diagnosis code. Established by the American Medical Association.

**Credentialing** - This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks.

**Credit Balance** - The balance that’s shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example $50-). It may also be shown in parenthesis; ($50). The provider may owe the patient a refund.
**Crossover claim** - When claim information is automatically sent from Medicare to the secondary insurance such as Medicaid.

**Date of Service (DOS)** - Date that health care services were provided.

**Deductible** - Amount patient must pay before insurance coverage begins. For example, a patient could have a $1000 deductible per year before their health insurance will begin paying. This could take several doctor’s visits or prescriptions to reach the deductible.

**Demographics** - Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

**DOB** - Abbreviation for Date of Birth.

**Downcoding** - When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurers’ computer processing system converts the code submitted down to the closest code in use, which usually reduces the payment.

**Durable Medical Equipment** – Medical Supplies

**Duplicate Coverage Inquiry (DCI)** - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

**Dx** - Abbreviation for diagnosis code (ICD-10 code).

**Electronic Claim** - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

**Electronic Funds Transfer (EFT)** - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

**E/M** - Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians or other qualified staff to access (or evaluate) patients’ treatment needs.

**EMR** - Electronic Medical Records. This is a medical record in digital format of a patient’s hospital or provider treatment.

**Enrollee** - Individual covered by health insurance.

**EOB** - Explanation of Benefits. One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

**ERA** - Electronic Remittance Advice. This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in accordance to the HIPAA X12N 835 standard.

**ERISA** - Employee Retirement Income Security Act of 1974. This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law.

**Fee For Service** - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

**Fee Schedule** - Cost associated with each treatment/CPT medical billing codes.
**Financial Responsibility** - The portion of the charges that are the responsibility of the patient or insured.

**Fiscal Intermediary (FI)** - A Medicare representative who processes Medicare claims.

**Formulary** - A list of prescription drug costs which an insurance company will provide reimbursement for.

**Fraud** - When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

**GPH** - Group Health Plan. A means for one or more employers who provide health benefits or medical care for their employees (or former employees).

**Group Name** - Name of the group or insurance plan that insures the patient.

**Group Number** - Number assigned by insurance company to identify the group under which a patient is insured.

**Guarantor** - A responsible party and/or insured party who is not a patient.

**HCPCS** - Health Care Financing Administration Common Procedure Coding System. Three level system of codes. CPT is Level I. A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a “procedure code” in the medical billing glossary.

The three HCPCS levels are:
- **Level II** - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- **Level III** - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

**Health Savings Account** - A tax-advantaged medical savings account available to employees who are enrolled in a High-Deductible health plan. This account is to be used for medical expenses only.

**Healthcare Insurance** - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy, which covers the beneficiary's family members. May include coverage for disability or accidental death or dismemberment.

**Healthcare Provider** - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage.

**Health Care Reform Act** - Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. Also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

**HIC** - Health Insurance Claim. This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

**HIPAA** - Health Insurance Portability and Accountability Act. Several federal regulations intended to improve the efficiency and effectiveness of health care. HIPAA has introduced a lot
of new medical billing terms.

**HMO** - Health Maintenance Organization. A type of health care plan that places restrictions on treatments.

**ICD-10 Code** - 10th revision of the International Classification of Diseases. Uses 3 to 7 digit. Includes additional digits to allow more available codes. The U.S. Department of Health and Human Services implementation deadline was October, 2015 for ICD-10.

**Indemnity** - Also referred to as fee-for-service. This is a type of commercial insurance were the patient can use any provider or hospital.

**In-Network (or Participating)** - An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

**MAC** - Medicare Administrative Contractor. Contractors who process Medicare claims.

**Managed Care Plan** - Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

**Maximum Out of Pocket** - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

**Medical Assistant** - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician’s assistant, nurse, nurse practitioner, etc.

**Medical Coder** - Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-10 and corresponding CPT treatment codes and any related CPT modifiers.

**Medical Billing Specialist** - Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology.

**Medical Necessity** - Medical service or procedure that is performed for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

**Medical Record Number** - A unique number assigned by the provider or health care facility to identify the patient medical record.

**MSP** - Medicare Secondary Payer.

**Medical Savings Account** – Tax-exempt account for paying medical expenses administered by a third-party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account.

**Medicare** - Insurance provided by the federal government for people over 65 or people under 65 with certain restrictions:

- Medicare Part A - Hospital coverage
- Medicare Part B - Physicians visits and outpatient procedures
- Medicare Part D - Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.
**Medicare Coinsurance Days** - Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

**Medicare Donut Hole** - The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs.

**Medicaid** - Insurance coverage for low-income patients. Funded by Federal and state government and administered by states.

**Medigap** - Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare.

**Modifier** - Modifier to a CPT treatment code that provides additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

**N/C** - Non-Covered Charge. A procedure not covered by the patients’ health insurance plan.

**NEC** - Not Elsewhere Classifiable. Medical billing terminology used in ICD when information needed to code the term in a more specific category is not available.

**Network Provider** - Health care provider who is contracted with an insurance provider to provide care at a negotiated cost.

**Non-participation (Non-Par)** - When a healthcare provider chooses not to accept Medicare approved payment amounts as payment in full.

**NOS** - Not Otherwise Specified. Used in ICD for unspecified diagnosis.

**NPI Number** - National Provider Identifier. A unique 10-digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).


**Out-of Network (or Non-Participating)** - A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of-network provider.

**Out-Of-Pocket Maximum** - The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurers’ obligation. These out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

**Outpatient** - Typically treatment in a physician’s office, clinic, or day surgery facility lasting less than one day.

**Patient Responsibility** - The amount a patient is responsible for paying that is not covered by the insurance plan.

**PCP** - Primary Care Physician - Usually the physician who provides initial care and coordinates additional care if necessary.

**POS** - Point-of-Service plan. Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers.

**POS (Used on Claims)** - Place of Service. Medical billing terminology used on medical
insurance claims - such as the CMS 1500 block 24B. A two-digit code which defines where the procedure was performed. For example 71 is for the Health Departments and 12 is for home.

PPO - Preferred Provider Organization. Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO.

Practice Management Software - software used for the daily operations of a provider’s office. Typically used for appointment scheduling and billing.

Preauthorization - Requirement of insurance plan for primary care doctor to notify the patient’s insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

Pre-Certification - Sometimes required by the patient’s insurance company to determine medical necessity for the services proposed or rendered. This doesn’t guarantee the benefits will be paid.

Predetermination - Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment.

Pre-existing Condition (PEC) - A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient’s effective date of coverage. A Preexisting condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

Pre-existing Condition Exclusion - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective.

Premium - The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

Privacy Rule - The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information about a patient’s health status, treatment, or payments.

Provider - Physician or medical care facility (hospital) who provides health care services.

PTAN - Provider Transaction Access Number. Also known as the legacy Medicare number.

Referral - When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

Relative Value Unit - Measure of value used by Medicare to determine how much to reimburse for a procedure by using a formula

Remittance Advice (R/A or RA) - A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits).

Responsible Party - The person responsible for paying a patient’s medical bill. Also referred to as the guarantor.

Self-Referral - When a patient sees a specialist without a primary physician referral.

Self Pay - Payment made at the time of service by the patient.

Secondary Insurance Claim - Claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

Secondary Procedure - When a second CPT procedure is performed during the same physician visit as the primary procedure.

Security Standard - Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is
a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

**SOF** - Signature on File.

**Specialist** - Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

**Subscriber** - Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder.

**Superbill** - One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-10 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

**Supplemental Insurance** - Additional insurance policy that covers claims for deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

**TAR** - Treatment Authorization Request. An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

**Taxonomy Code** - Specialty standard codes used to indicate a provider’s specialty sometimes required to process a claim.

**Term Date** - Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

**Tertiary Insurance Claim** - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

**Third-Party Administrator (TPA)** - An independent corporate entity or person (third-party) who administers group benefits, claims and administration for a self-insured company or group.

**TIN** - Tax Identification Number. Also known as Employer Identification Number (EIN).

**TOP** - Triple Option Plan. An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

**TOS** - Type of Service. Description of the category of service performed.

**TRICARE** - This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

**UB04** - Claim form for hospitals, clinics, or any provider billing for facility fees.

**Unbundling** - Submitting several CPT treatment codes when only one code is necessary.

**Untimely Submission** - Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

**Upcoding** - An illegal practice of assigning an ICD-10 diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer.

**UPIN** - Unique Physician Identification Number. 6-digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

**Utilization Limit** - The limits that Medicare sets on how many times certain services can be provided within a year. The patient’s claim can be denied if the services exceed this limit.

**Utilization Review (UR)** - Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures.
**V-Codes** - ICD-10-CM coding classification to identify health care for reasons other than injury or illness.

**Workers Comp** - Insurance claim that results from a work-related injury or illness.

**Write-off** - Typically reference to the difference between what the physician charges and what the insurance plan contractually allows and the patient is not responsible for paying. May also be referred to as "not covered" in some glossary of billing terms.
Resources


https://www.aapc.com/icd-10-newsletter/issue41.html

http://archived.naccho.org/toolbox/

http://archived.naccho.org/topics/HPDP/billing/

http://www.cdc.gov/phlp/docs/hd-billing.pdf


http://www.dph.illinois.gov/laws-rules

http://www.hfs.illinois.gov/html/093013n.html

http://www.icd10data.com/ICD10CM/Codes/A00-B99/B20-B20/B20-/B20


http://library.ahima.org/doc?oid=106660#.WIJifoWcHDc