Telehealth HIV Billing

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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 warrantees of fitness for a particular purpose. Most of this white paper will focus on HIV services billing for public health 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 for these services requires a paradigm shift for both LHD staff and individuals seeking services. For LHDs, billing is a comprehensive approach and not isolated to just one clinical service. Most LHDs establish billing programs to include all of the clinical services that they provide.

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, Family Health Plus (FHP) and Child Health Plus (CHP) fund HIV services for individuals with limited financial means.

Finally, there are a number of laws and program requirements that require LHDs to 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 telehealth 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.

Telehealth 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. The National Alliance of State and Territorial AIDS Directors (NASTAD) distributed a survey recently to update information about health department-supported testing programs. The survey asked several questions about health department practices regarding seeking reimbursement from Medicaid, Medicare, or other third-party payers for HIV testing services.

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.
- Starting March 6, 2020, under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act:
    - ✓ A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.
    - ✓ The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.

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

The HIV telehealth 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 telehealth 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 Billing for HIV Services

Please note the following regulations affecting billing for Telehealth HIV services in the State of Illinois. Please check with your payer representatives if telehealth HIV services are paid for per visit or other determinant.

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.

HIV 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)
- Place of Service (POS) 02 – for telehealth HIV services

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
- Telehealth visits

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).

Under 1135 waiver telehealth visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

- Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.
- Email, telephone, and fax are rarely acceptable forms of delivery unless they are in conjunction with some other type of system.

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.

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

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

Also, there are other types of visits due to telehealth that may be reimbursable by payers:

- E-visits = Short patient-initiated communications with a healthcare practitioner.
- Virtual Check-ins = Non-face-to-face patient-initiated communications through an online patient portal.

Virtual check-ins are:

- For patients with an established (or existing) relationship with a physician or certain practitioners.
- Where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).
- The patient must verbally consent to receive virtual check-in services.
- The Medicare coinsurance and deductible would generally apply to these services.
- Doctors and certain practitioners may bill for these virtual check in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012).
- Captured video or images can be sent to a physician (HCPCS code G2010).

E-visits are for:

- The services billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
- Where the patient must verbally consent to receive virtual check-in services.

- Where the Medicare coinsurance and deductible would apply to these services.
- Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal.
- Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:
    - 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
    - 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
    - 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

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. LHD's should utilize online insurance portals first as it could save time from having to call. In regards to authorization, the services provided at the LHD's 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:

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. The 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.

Telehealth HIV 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

HIV 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, co pay, 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

Telehealth HIV 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.

Telehealth HIV sessions should be as thoroughly documented as all other patient/client encounters. Records minimally should include:

- ✓ Patient/client name.
- ✓ Patient/client identification number at originating site.
- ✓ Date of service.
- ✓ Referring practitioner's name.
- ✓ Consulting practitioner's name.
- ✓ Provider organization's name.
- ✓ Type of HIV evaluation to be performed.
- ✓ Informed consent documentation.
- ✓ HIV Evaluation results.
- ✓ HIV Diagnosis/impression of providers.
- ✓ Recommendations for further treatment.

The use of standardized intake and consultation forms can help providers achieve compliance with documentation parameters.

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.

Telehealth HIV 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.

Possible Funding Streams for HIV Services

Routine HIV Testing funding streams may include:

- Medicaid provides coverage for routine HIV testing.
- Private insurers provide coverage in alignment with internal policies and guidelines.
- Illinois state Medicaid is a managed care system.
    - Bundled payments.

- Limited fee-for-service payments.
- Third party payers may cover HIV testing, but this does not guarantee increased revenue.
- Veterans Administration.
- Discretionary federal funding through CDC, Ryan White, community health centers, rural health clinics; SAMHSA programs including substance abuse block grant.
- Safety net providers– public hospitals, uncompensated care funds.

HIV Services Billing Maintenance

Providers should educate their billing team on the services, HIV related terms, HIV care continuum, clinical staffing model, and visit frequency and duration.

If your HIV program is in a large department, it is important for you to understand and give feed back about terms likely to have negative impact on quality or payment adequacy. While some Medicaid MCO contracts, for example, have HIV specific terms, many contracts do not address HIV.

Your department's negotiation team may suggest HIV-related terms. These terms may include:
•The HIV care continuum (including patient education, prevention, care, and therapeutics)
•The typical HIV clinical staffing model (which is based on ID and other specialty care)
•The common visit frequency and duration
•Formulary adequacy must ensure ready access to HIV, OI prophylaxis, HepC, and other common medications
•The array of preventive, clinical, care management, and other services offered by your program may be offered for purchase by the insurer
•The adequacy of payment models is critical to ensure your costs are covered.

Confidentiality in Billing

Another public health department concern is billing for confidential services. Most private insurance companies send an explanation of benefits (EOB) to the insured policy holder, which may breach the confidentiality of adolescents or spouses for services such as HIV testing and treatment. Public health departments can protect confidentiality by asking clients upfront if they will let the health department bill their private insurance. This small change can ensure that clients were aware of their privacy rights and that EOBs were sent by insurance plans. Those adult clients that do not want the EOB sent could be asked to pay for the services on a sliding scale.

Telehealth HIV Legislation

Telehealth/Telemedicine Parity Laws: These laws require private payers in a state to reimburse for telehealth services the same way they would for an in-person service. The HEALTH Act (HR 7187), introduced in June 2020 by Rep. Glenn Thompson (R-PA), made permanent Medicare coverage for telehealth services provided at federally qualified health centers (FQHCs) and Rural Health Clinics (RHC).

Appendices

Acronyms

ACA	Affordable Care Act
AMA	American Medical Association
BCBS	Blue Cross Blue Shield
C MS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidate Omnibus Budget Reconciliation Act
CPT	Current Procedural Terminology
DCI	Duplicate Coverage Inquiry
DME	Durable Medical Equipment
DOB	Date of Birth
DOS	Date of Service
DX	Diagnosis Code (ICD-9 or ICD-10)
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
E/M	Evaluation and Management
EMR	Electronic Medical Record
EHR	Electronic Health Record
EOB	Explanation of Benefits
EOP	Explanation of Payment
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-for-Service
FI	Fiscal Intermediary
GHP	Group Health Plan
HC	Health Check
HCPCS	Healthcare Common Procedure Coding System
HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HSA	Health Savings Account
ICD-10	International Classification of Diseases, 10th edition
MAC	Medicare Administrative Contractor
MCO	Managed Care Organization
MSP	Medicare Secondary Payer
N/C	Non-Covered Charge
NDC	National Drug Code
NEC	Not Elsewhere Classifiable
NOS	Not Otherwise Classifiable

NPI	National Provider Identifier
OI	Other insurance
OIG	Office of Inspector General
PCP	Primary Care Provider
PEC	Pre-existing Condition
PHI	Protected Health Information
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PTAN	Provider Transaction Access Number
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RVU	Relative Value Unit
SOF	Signature on File
TAR	Treatment Authorization Request
TIN	Tax Identification Number
TOS	Type of Service
TPA	Third-Party Administrator
TPL	Third-Party Liability
UB	Uniform Billing
UR	Utilization Review

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 a CMS-1500 form. This form is distinguished by its red ink.
Coding - Medical billing coding involves taking the doctors 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 when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees. 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 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 is 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 according 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 employer 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 I - American Medical Associations Current Procedural Terminology (CPT) codes.
● 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 into our vocabulary lately.
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 digits. 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 where 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 network. 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 on 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 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 provide 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).

OIG - Office of Inspector General - Part of department of Health and Human Services. Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices.

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 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 patients 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 kind of 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 similar to CMS 1500. Replaces the UB92 form.
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 patients 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. May also be referred to as "not covered" in some glossary of billing terms.

Resources

http://www.aafp.org/practice-management/payment/coding.html

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

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

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

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

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

http://www.jeffersoncountypublichealth.org/pdf/LHJ_Billing_Resource_Guide.pdf