Telehealth Billing for HIV - Pre-Exposure Prophylaxis (PrEP)

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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-PrEP 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.

Contents

Executive Summary

As computer and mobile device usage increases, telehealth will become a common type of health care delivery. Telehealth is now being used in fields such as chronic disease monitoring and management, dentistry, physical and occupational therapy, and counseling.

Regarding pre-exposure prophylaxis (PrEP), telehealth specifically refers to the delivery of PrEP related clinical services to prevent HIV. Where PrEP telehealth is available, those receiving PrEP can now have virtual visits with their provider, as opposed to having a physical visit.

PrEP telehealth can increase PrEP access for those most vulnerable to HIV who may not otherwise have access due to social stigma or distance from the closest PrEP provider. Because telehealth allows patients to have virtual provider visits, it can alleviate some of the difficulties surrounding geographic isolation, such as in rural areas, or reluctance to access PrEP because of fear of stigma.

Telehealth can also reduce PrEP delivery barriers related to local health care professional shortages since, again, patients do not necessarily have to physically visit a provider. A third advantage of PrEP telehealth is that it can support patients who struggle with medication adherence. The development and use of real-time electronic adherence monitors, digital medicine systems, and short message service (SMS) surveys in PrEP research illustrates technology advances that may improve adherence measurements. In the future, this could mean intervening and improving adherence to PrEP in real time.

HIV-PrEP 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.

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

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-PrEP services: local delivery and billing practices for a range of public health services, HIV services volume, PrEP medications and the public and commercial insurance markets.

This paper provides an overview for public health telehealth HIV-PrEP billing.

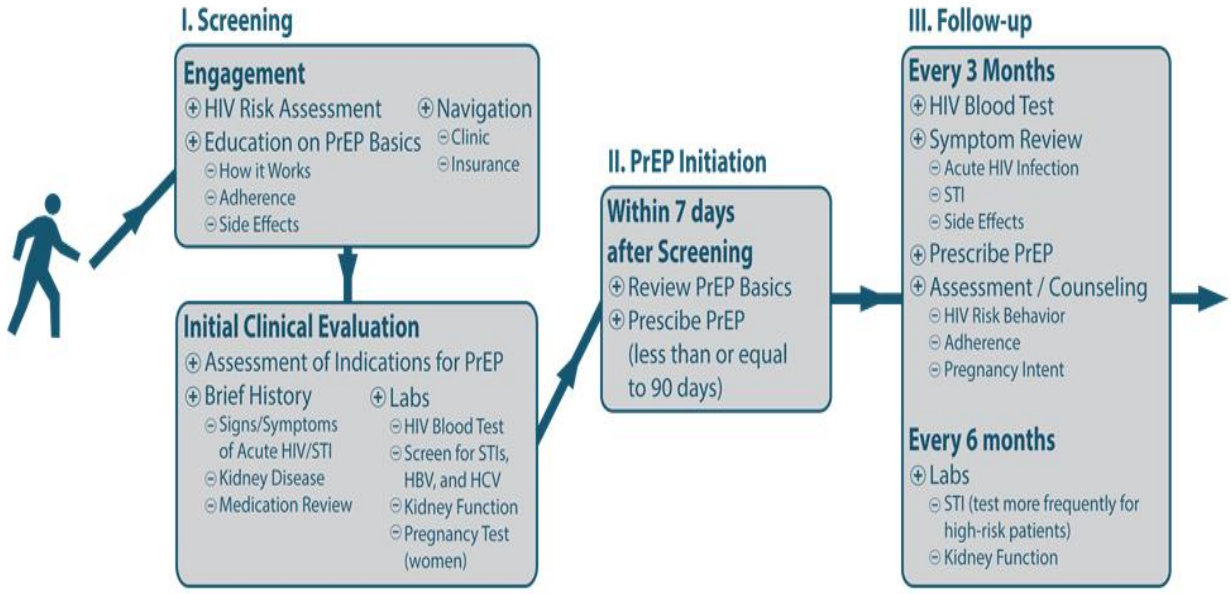
Overview of HIV-PrEP

PrEP (pre-exposure prophylaxis) is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. There are two medications approved for use as PrEP: Truvada® and Descovy®.

- Truvada® is for all people at risk through sex or injection drug use.
- Descovy® is for people at risk through sex, except for people assigned female at birth who are at risk of getting HIV from vaginal sex.

How PrEP is implemented varies based on the clinical setting (community health center, STI clinic, pharmacy, etc.), the population of interest (e.g., MSM, transgender women, people who inject drugs, cisgender women, etc.), and the local health insurance environment and availability of drug assistance programs. Regardless of the model of care, successful PrEP programs address three core tasks: 1. Identifying and engaging PrEP candidates 2. Completing the initial and follow-up medical evaluations 3. Employing health insurance and drug assistance programs to overcome financial barriers.

The HIV-PrEP care system can involve 3 phases such as:



Screening is the first phase in the delivery of PrEP. The screening phase includes the steps engagement, navigation, and an initial clinical evaluation. Screening is often the most time-intensive phase within the PrEP Care System. Engagement includes an HIV risk assessment to identify persons who may benefit from PrEP. It also includes education about PrEP basics, including how PrEP works, the importance of medication adherence, and medication side effects. Navigation services should be offered at the time of PrEP engagement to guide persons in need of PrEP to clinical services and insurance options that will pay for PrEP. If the client does

not have insurance, navigators or clinic staff should assist the client in obtaining insurance or access to medication assistance programs.

The initial clinical evaluation is the final step in the screening phase and is performed by a medical provider. It occurs before prescribing PrEP and includes a brief history, including signs or symptoms of acute HIV or sexually transmitted diseases (STDs), history of kidney disease, a medication review and an assessment of indications for PrEP. The provider also should conduct an HIV blood test, evaluate kidney function, check hepatitis B virus (HBV) and hepatitis C virus (HCV) serology, test for STDs, and conduct a pregnancy test for women.

The second phase is PrEP Initiation. Where the initial clinical evaluation is an assessment of indications for PrEP including an assessment of laboratory values, PrEP initiation refers to when the PrEP medication is prescribed. For locations where laboratory testing results, including an HIV test, are available on the same day as drawn, the initiation phase may occur on the same day as the initial clinical evaluation. When it is not possible to rule out HIV and normal renal function on the same day as the initial clinical evaluation, it is recommended to initiate PrEP within seven days of the HIV test to minimize the risk of HIV acquisition between the time of HIV testing and PrEP initiation.

At the time of PrEP initiation, PrEP basics are reviewed, and PrEP medication is prescribed. Medication can be provided directly by the clinic or by providing a prescription to an outside pharmacy. Paying for PrEP is part of this phase. Some insurers may require a prior authorization to cover the cost of medication or services. Medication can be accessed through drug assistance programs, like *Ready, Set, PrEP*. *Ready, Set, PrEP* provides medication for those without drug prescription coverage or insurance.

The Third phase is Follow-Up. According to PrEP clinical practice guidelines:

- Every three months:
    - Conduct HIV blood test
    - Conduct a symptom review of STDs, acute HIV infection, and side effects
    - Conduct HIV risk behavior assessment
    - Screen for STDs in sexually active adults and adolescents with signs or symptoms of an STD and in men who have sex with men (MSM) at high risk, defined as those with a recent bacterial STD or those with multiple sex partners
    - Provide adherence counseling and answer questions
    - Assess pregnancy intent and conduct a pregnancy test (if applicable)
    - Provide a new 3-month prescription for PrEP

- Every six months:
    - Screen for STDs in sexually active adults and adolescents who do not meet the criteria for more frequent screening
    - Assess kidney function

The HIV-PrEP Care System could be provided through 3 separate or combination of, which could include public health departments, community-based organizations (CBOs) and/or clinics.

Under the **public health department model**, PrEP is listed as an essential component of the notice of funding opportunity (NOFO) or PS18-1802. According to this NOFO, health departments should work to expand awareness of and access to PrEP through:

- Screening for PrEP eligibility
- Linkage and support for PrEP
- Supporting adherence to PrEP
- Supporting access to PrEP:
    - Increasing consumer knowledge
    - Enhancing provider knowledge and support for PrEP

Funds from PS18-1802 cannot be used to pay for medications, clinical care, or labs other than HIV or viral hepatitis screening. However, health departments can conduct some PrEP-related services within STD clinics. These can range from counseling and referral services to the use of other funds for the provision of clinical services for PrEP. States may also consider implementing PrEP patient assistance programs for the uninsured to assist with payment for clinic visits and laboratory costs related to PrEP.

Screening for PrEP Eligibility: PrEP services and referrals can be worked into health departments' pre-existing HIV prevention strategies. At the time of HIV testing, presentation for an STD, or when accessing post-exposure prophylaxis services, patients should be evaluated for PrEP eligibility and linked to a PrEP provider, as appropriate.

Linkage and Support for PrEP: Health departments can help educate and motivate on PrEP implementation using social and behavioral strategies and interventions, such as PrEP navigation, education, and counseling services. Health departments should evaluate the availability of PrEP services in their jurisdictions to determine areas of need to scale up services and increase use.

Support Adherence to PrEP: PrEP users should be provided all the information and support needed to ensure they take PrEP daily as directed. Health departments can support clinics and

CBOs with adherence-related activities by providing PrEP education to clinical providers and providing resources for patients.

Support Access to PrEP: Health departments can also address PrEP access, which may vary among jurisdictions. Using non-federal, local funds, health departments may be able to establish PrEP patient assistance programs within their jurisdictions. California, Virginia, Massachusetts, the District of Columbia, New York, and Washington have implemented PrEP assistance programs to increase access to and use of PrEP.

Increase Consumer Knowledge for PrEP: Health departments can help increase knowledge of PrEP within the community to accept PrEP use among HIV-negative persons at risk of HIV infection. Community-wide education on PrEP can occur in a variety of complementary ways, including:

- Visuals, brochures, and pamphlets;
- Media campaigns, including the use of social media;
- Radio and television public service announcements; and
- Partnering with community members, key stakeholders, and peers to build trust and credibility.

Enhance Provider Knowledge and Support of PrEP: Health departments can develop their own educational materials for PrEP and provide training for local clinicians through public health detailing and implementation workshops.

Compiling and maintaining a directory for PrEP providers and PrEP-related services is a great way to provide information to providers, the public, and partner organizations on the availability of services. This directory information can also be shared with PrEP Locator to help build the database of this online resource provided by CDC's National Prevention Information Network.

Health departments seeking to increase their capacity around PrEP can utilize CDC's Capacity Building Assistance (CBA) Tracking System (CTS), a web-based application that allows CDC-funded organizations to request CBA services. A user ID and password are required to access the application.

Under the **community-based organizations model**, non-clinical CBOs play an important role in the PrEP care system. CBOs can provide the following key services in support of PrEP:

- Promotion and education
- Engagement, identification, and recruitment; Evidence-based interventions supporting PrEP uptake

- Navigation
- Directories of health and prevention services

Promotion and Education: CBOs have an important role in promoting PrEP and providing education on PrEP to populations in need. Individualized education on PrEP should be routine and integrated into community-based prevention services, such as outreach and testing services for HIV and STDs. Community-wide education on PrEP can occur in a variety of complementary ways, including:

- Visuals, brochures, and pamphlets; Media campaigns, including the use of social media; Radio and television public service announcements; and Partnerships with community members, key stakeholders, and peers to build trust and credibility.

Engagement, Identification, and Recruitment: Persons at high risk for HIV acquisition can be identified for PrEP clinical services through outreach, testing, and other program contact, services, and interventions. Those who are at risk of HIV acquisition often encounter barriers, such as stigma, medical mistrust, and perceived payment barriers, that prevent them from receiving health services. Targeted recruitment and other PrEP service efforts can be used to reach those who are at risk and traditionally underserved by HIV prevention efforts. In addition to education about PrEP, candidates may need motivation to use it. Motivational interviewing or counseling may be beneficial in influencing persons to accept PrEP as a prevention method.

Evidence-Based Interventions Supporting PrEP Uptake: There are several appropriate high-impact prevention, or HIP, interventions for promoting PrEP.

- **PROMISE for HIP** promotes PrEP by creating and distributing community- and population-specific role model stories to spread educational messages and modeling community member experiences and endorsements.
- **Popular Opinion Leader (POL)** focuses on identifying, recruiting, and supporting opinion leaders (persons who have influence in and across populations) to endorse an intervention like PrEP so that it becomes a prevention innovation through social network acceptance and uptake.
- **d-up: Defend Yourself!** is based on POL but meant for black gay, bisexual, and other men who have sex with men (MSM). d-up: Defend Yourself! includes skills building for coping with community- and individual-level stigma.
- **Mpowerment** brings young MSM together into a dedicated community space, and empowers them to educate, organize, support, and promote innovations like PrEP.

Navigation: Navigation for PrEP includes identifying and linking persons in need of PrEP to healthcare systems, assisting with health insurance, identifying and reducing barriers to care, and tailoring education to the client to influence their health-related attitudes and behaviors. CBOs are often able to identify and guide PrEP candidates because they work with persons in

need of PrEP during existing services delivery. Integrating PrEP education and referrals into program services is an effective way to promote PrEP to those who are likely candidates. Examples include STD services, HIV testing services, and partner services.

CBOs that do not provide clinical services should develop working relationships with PrEP clinicians to facilitate linkage of community members to PrEP services. Clinical programs may also want to involve staff from CBOs to help to manage PrEP patients. Working relationships with behavioral health clinics, substance abuse treatment clinics, and other clinical service providers may be beneficial in proving services to persons in need of PrEP.

PrEP candidates may also need assistance in navigating payment coverage, transportation, and communication with clinicians, among other services. Developing a comprehensive directory of available, accessible, and acceptable services can help CBOs refer individuals to these services.

Directories of Health Services including PrEP: A comprehensive directory of available, accessible, and acceptable services should support navigation and guidance of clients. The local health department or other local CBOs may create such a directory. Jurisdictional planning groups routinely create and maintain resource directories. If none are available in your jurisdiction, you may want to create a directory for serving your PrEP clients. Providers in local directories should also be registered at PrEP Locator an online PrEP provider resource maintained by the CDC's National Prevention Information Network (NPIN). CBOs may also need to have memoranda of agreement with service providers to facilitate engaging clients with their services. CBOs seeking to increase their capacity around PrEP can also utilize CDC's Capacity Building Assistance (CBA) Tracking System (CTS), a web-based application that allows CDC-funded organizations to request CBA services. A user ID and password are required to access the application.

Under the **clinic model**, clinics can provide the following key services in support of PrEP:

- Assessment of indications for PrEP;
- Prescribing;
- HIV/STD testing;
- Adherence support;
- Education and assistance; and
- Additional testing and follow-up.

Clinics can directly provide PrEP services to patients. The U.S. Public Health Service's Clinical Practice Guideline updated in 2017, provides the framework for delivering high-impact prevention of HIV with the use of emtricitabine/tenofovir disoproxil fumarate, or Truvada®. PrEP can be offered in conjunction with primary care services and does not need to be prescribed by a specialist.

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- HIV/STD testing;
- Adherence support;
- Education and assistance; and
- Additional testing and follow-up.

Assessment of Indications for PrEP: PrEP is indicated for HIV-negative persons who:

- Have shared injection or drug preparation equipment in the last 6 months;
- Have condomless anal or vaginal sex; and/or
- Had a bacterial STD within the last 6 months.

PrEP should be used when the HIV status of the partner or partners is either unknown or positive (especially if the positive partner is not on HIV treatment or has a detectable viral load). Sections 6 and 7 of the U.S. Public Health Service's Clinical Practice Guideline contain tools clinicians may use to determine whether MSM or PWID are at high risk for HIV acquisition and likely candidates for PrEP.

Prescribing PrEP: For more information on prescribing PrEP, please see the U.S. Public Health Service's Clinical Practice Guideline. The CDC also has available a CME online training on Prescribing PrEP (see PrEP Training below for information on accessing this online training).

HIV/STD Testing: HIV and STD testing are essential components of the PrEP care system. Before prescribing PrEP, the clinician must rule out an HIV infection, including an assessment of recent potential exposure and signs and symptoms of acute HIV. If there has been a potential HIV exposure within the last 72 hours, post-exposure prophylaxis should be considered prior to initiating PrEP.

While on PrEP, a person is advised to also get periodic HIV and STD testing. HIV testing should be done every 3 months. If the person acquires HIV while taking PrEP, they must immediately be provided a full antiretroviral therapy (ART) regimen to prevent drug resistance.

PrEP provides protection from HIV, not from bacterial STDs. STD screening is recommended at least every 6 months for persons who are sexually active while taking PrEP. STD screening should be done every 3 months for men and women with signs and symptoms of a bacterial STD or for MSM or others with a high risk of STDs, defined as persons with multiple sex partners or those with prior STD diagnosis. Diagnosed STD should be treated immediately. This will further reduce the risk of HIV acquisition and prevent the spread of STD in the community.

Adherence Support: PrEP should be taken every day. PrEP users should be educated on the importance of adherence. They may need help creating a PrEP adherence plan — including a backup plan for missed doses. Clinics can collaborate with CBOs to provide adherence support to patients who need it.

Education and Assistance: Patients starting PrEP should be counseled on:

- What PrEP medication is and how it works;
- The importance of adherence;
- Potential side effects and their management;
- Safer sex and sterile injection practices; and
- When to contact their provider.

PrEP is part of a system of care that includes regular medical visits; adherence coaching; discussion of safer sex practices; as well as screening for HIV, STDs, and medication side effects. Although PrEP medication is covered by Medicaid in most states and most commercial insurance companies, some patients may have high co-pays for the medication. PrEP users may need education and assistance in each of these areas. Clinic benefits managers, social workers, as well as CBOs, may be able to support a clinic's clients with payment assistance education and navigation.

Additional Testing and Follow-Up: Providers should discuss treatment options with patients following their test results. The following tests are performed before PrEP is initiated, and then periodically to monitor side effects. Initial baseline testing, prior to starting PrEP, includes:

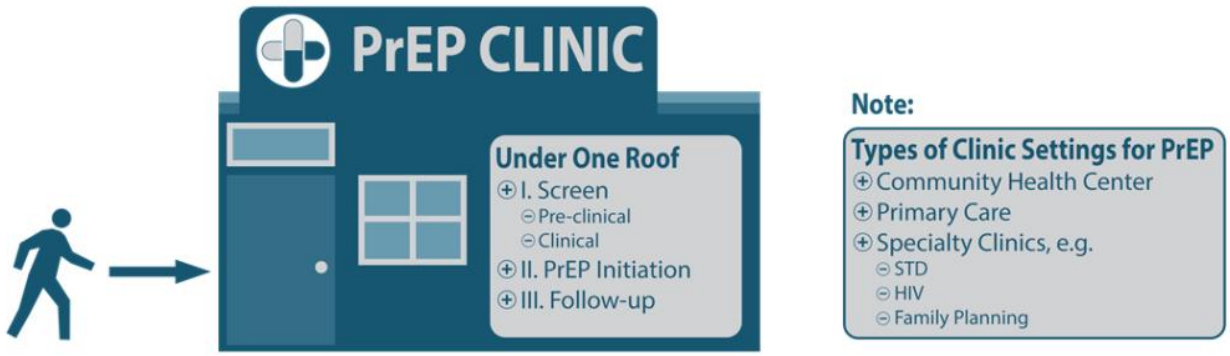
- Chlamydia, gonorrhea, and syphilis;
- HIV;
- Kidney function;
- Pregnancy and pregnancy intent; and
- Hepatitis B and C virus.

Follow-up testing includes:

- HIV, every 3 months;
- STD, every 3 to 6 months;
- Kidney function, every 6 months;
- Pregnancy and assess pregnancy intent every 3 months; and

- For PrEP users who have chronic hepatitis B infection, HBV DNA test every 6 to 12 months while prescribed PrEP.

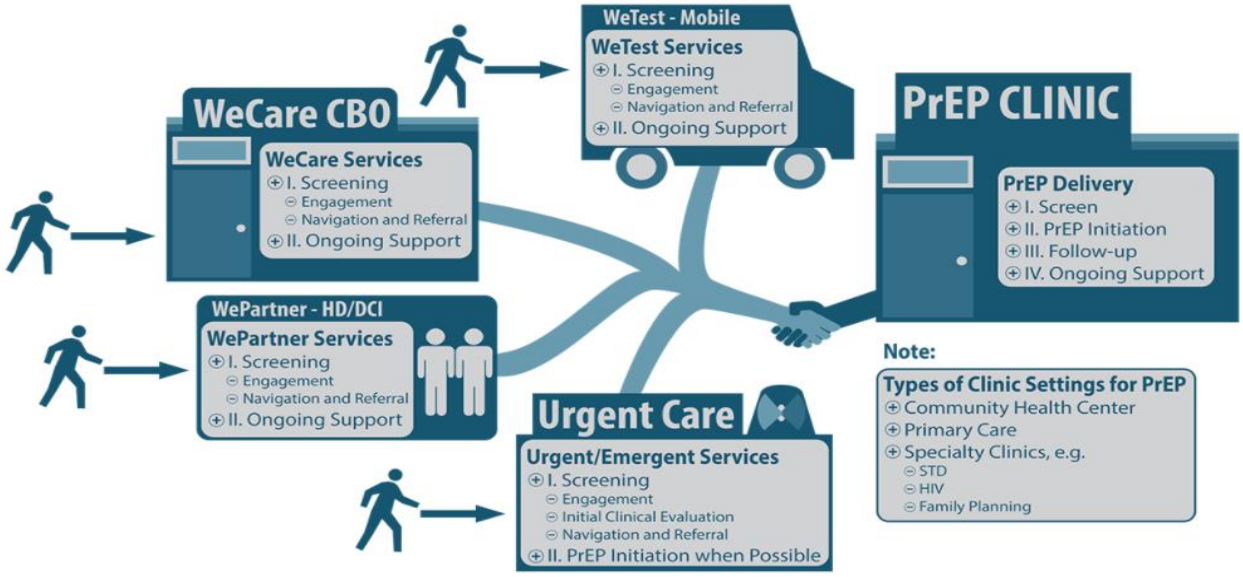
PrEP delivery models for assessment and monitoring include Health departments, CBOs, and healthcare organizations. Each play a role. PrEP delivery can be done using the clinic-based model or the collaborative model. Below is the Clinic-based model:



This model consists of a clinic that offers the full spectrum of services within the PrEP Care System at a single location. The model will need skilled personnel, adequate equipment, and access to lab services; it also requires a broad spectrum of resources available under one roof to address each phase of the PrEP Care System.

So, who is involved? Clinics would manage most or all aspects of the PrEP Care System under the clinic-based model, but CBOs might provide in-house counseling and health departments may assist with lab services, such as HIV and STD testing. What are the Advantages? This model is easiest for clients as all their medical care needs for PrEP are provided at one location. Furthermore, clients have access to the clinic resources and provider networks. A challenge could be maintaining adequate resources to meet clients' needs which could be costly and burdensome if not already existing before PrEP care is initiated.

Below is the Collaborative Model:



In the collaborative model, local health departments, CBOs, and clinics work together to provide services. Health departments, CBOs, and clinics coordinate efforts in an efficient and sustainable way. The graphic illustrates the variety of combinations of services that can be provided within the three phases of the PrEP care system by health departments, CBOs, and clinics.

Advantages: The collaborative model provides a particularly useful strategy when linking harder-to-reach individuals to PrEP, such as people who do not have insurance or may not routinely seek care. This is accomplished through the collaboration between trusted, population-specific CBOs and partner services for persons at particularly high risk for HIV infection.

Challenges: Collaborations and service agreements are needed between these providers. Due to competing priorities and constrained resources, establishing these agreements can be challenging and time consuming. Identifying a PrEP champion can help facilitate partnerships and streamline processes

Telehealth HIV-PrEP Legislation

Telehealth/Telemedicine Parity Laws require private payers in a state to reimburse for telehealth services the same way they would for an in-person service.

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.

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).

Regulations/Acts Affecting Billing for HIV-PrEP Services

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

Telehealth HIV-PrEP Billing Environment

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.

Please note that fee for service Medicaid covers 5 types of HIV visits where 3 have to do with testing (certain visits can be billed same day). Managed Care Organizations and commercial (private) plans have an entirely separate set of codes to use but similarly, will allow for same day billing of these visits. Please check with the individual payers for what they will pay for and exclude. Under the 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.

Under the Illinois Department of Healthcare & Family Services' (also referred to as IDHFS) telehealth policy, providers will be paid as either an Originating Site or Distant Site. The Originating Site is the site where the patient is located. An encounter clinic serving as the Originating Site shall be reimbursed for the medical encounter. The Originating Site encounter clinic must ensure and document that the Distant Site provider meets the Department's requirements for telehealth and telepsychiatry services since the clinic is responsible for reimbursement to the Distant Site provider.

The Distant Site is the site where the provider rendering the telehealth service is located. The Distant Site could be reimbursed 2 different ways. First, if the Originating Site is an encounter clinic, the Distant Site may not seek reimbursement from IDHFS for their services. The Originating Site encounter clinic is responsible for reimbursing the Distant Site. If the Originating Site is not an encounter clinic, the Distant Site encounter clinic can seek reimbursement from the Department. For telemedicine services, the provider rendering the service at the Distant Site can be a physician, podiatrist, advanced practice nurse (APN), or a Physician Assistant (PA) who is licensed by the State of Illinois or by the state where the participant is located.

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.

Also, Doctors and certain practitioners may bill for the 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). Virtual check-ins (HCPCS code G2012) and remote evaluation of recorded videos or images (HCPCS G2010) are also reimbursable using the new G0071 code.

So, now let us look closely at E-visits. E-visits services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. 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.

- *These services can only be reported when the billing practice has an established relationship with the patient.*
- *This is not limited to only rural settings. There are no geographic or location restrictions for these visits.*
- *Patients communicate with their doctors without going to the doctor's office by using online patient portals.*

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

Within HIV-PrEP Billing, the Revenue cycle management encompasses the entire process of managing claims, payment, and revenue generation. The above elements of the revenue cycle are based around the patient's visit to the public health department or clinic. If a public health department or clinic has clients that make appointments in advance, review the pre-visit information. For those that largely see walk-in clients, review the visit section. So, if you are scheduling patients ahead of the visit, information is collected before the visit, which 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. Prior to the visit is a good time to communicate to the patient the process for payment and the possible price of services, 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.

Now if your patients are walk-ins, 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 would be converted into CPT, ICD-10 and HCPCS codes and a claim should be submitted to the payers. Given the 1135 waiver, we have 2 new types of visits. The first is the E-visits. E-visits are short patient-initiated communications with a healthcare practitioner. The second are Virtual Check-ins, which are Non-face-to-face patient-initiated communications through an online patient portal.

HIV-PrEP Billing Key Steps

These duties can be spread out among different staff throughout the clinic. The billing process is a series of steps completed by billing specialists to ensure that public health departments/clinics are reimbursed for their services. Depending upon the circumstances, it can take a matter of days to complete, or may stretch over several weeks or months. While the process may differ slightly between public health departments/clinics, here is a general outline of a billing workflow.

Patient Registration

Patient registration is the first step on any billing flow chart. This is the collection of basic demographic information on a patient, including name, birth date, and the reason for a visit. Insurance information is collected, including the name of the insurance provider and the patient's policy number, and verified by medical billers. This information is used to set up a patient file that will be referred to during the medical billing process.

Financial Responsibility

The second step in the process is to determine financial responsibility for the visit. This means looking over the patient's insurance details to find out which procedures and services to be rendered during the visit are covered. If there are procedures or services that will not be covered, the patient is made aware that they will be financially responsible for those costs.

Superbill Creation

During check-in, the patient will be asked to complete forms for their file, or if it is a return visit, confirm or update information already on file. Identification will be requested, as well as a valid insurance card, and co-payments will be collected. Once the patient checks out, medical reports

from the visit are translated into diagnosis and procedure codes by a medical coder. Then, a report called a “superbill” may be compiled from all the information gathered thus far. It will include provider and clinician information, the patient's demographic information and medical history, information on the procedures and services performed, and the applicable diagnosis and procedure codes.

Claims Generation

The medical biller will then use the superbill to prepare a medical claim to be submitted to the patient's insurance company. Once the claim is created, the biller must go over it carefully to confirm that it meets payer and HIPPA compliance standards, including standards for medical coding and format.

Claims Submission

Once the claim has been checked for accuracy and compliance, submission is the next step. In most cases, the claim will be electronically transmitted to a clearinghouse, which is a third-party company that acts as a liaison between healthcare providers and health insurers. The exception to this rule is high-volume payers, such as Medicaid, who will accept claims directly from healthcare providers.

Monitor Claim Adjudication

Adjudication is the process by which payers evaluate medical claims and determine whether they are valid and compliant, and if so, the amount of reimbursement the provider will receive. During this process, the claim may be accepted, rejected or denied. An accepted claim will be paid according to the insurer’s agreements with the provider. A rejected claim is one that has errors that must be corrected, and the claim resubmitted. A denied claim is one that the payer refuses to reimburse.

Patient Statement Preparation

Once the claim has been processed, the patient is billed for any outstanding charges. The statement generally includes a detailed list of the procedures and services provided, their costs, the amount paid by insurance and the amount due from the patient.

Statement Follow-Up

The last step in the medical billing process is to make sure bills are paid. Medical billers must follow up with patients whose bills are delinquent, and, when necessary, send accounts to collection agencies.

In order to capture the correct billing information, there are different sources to collect the right billing Information. Most organizations may already be collecting the information you need to bill. The information you need can come from different sources.

• From Clients/Insurers: Member number, Group number, Plan address, Beneficiary/Subscriber number, signed consent to treat, bill and/or collect, and the client's social security number (may be optional)

• From Providers: Procedure and diagnosis information (CPT and ICD codes)

You can also call the insurance plan, Medicaid or Medicare to get the information you need.

Also, another key step is to review your current fee schedule. Review your fee structure, schedule, and policies to make sure they do not prevent you from receiving the maximum benefit from billing. Find out who, in your clinic, can change it. If you do not know, ask how they came up with the fees. Your fees may be set too low. Payments from insurance plans can boost your revenue if your charges are set right. Consider what your priorities are, who you serve and what those adjustments may mean to your clinic. Have a standard fee schedule posted for all your clients; Medicaid, Medicare, private insurance, and self-pay. You can still adjust your fees as needed through a sliding scale or time of service discount policies.

Without financial assistance for the costs of medication, clinical visits, and laboratory tests, PrEP would be prohibitively expensive for many patients. Many health centers which prescribe PrEP frequently employ staff members to help PrEP candidates navigate insurance and benefits program enrollment as well assist with identification of PrEP candidates and adherence to clinical follow-up.

The Ready, Set, PrEP program provides for PrEP at no cost to HIV-seronegative patients who lack prescription drug coverage and have a prescription for PrEP. The program does not cover the cost of laboratory tests or clinical visits.

Because PrEP has a grade A recommendation from the USPSTF, most private insurance plans and Medicaid programs must cover PrEP without cost sharing, starting in 2021. Some PrEP candidates may be eligible for but unenrolled in governmental health insurance programs such as Medicaid and Medicare. Clinical benefits managers and/or PrEP navigators can assist with insurance enrollment.

There are multiple billing methods. There are basically two options; 1. Pay someone to do it for you by working with a billing service or another Local Health Department (LHD). 2. Have your staff do it. You will need to be able to record and bill your services electronically. Few payers still allow you to send your claims on paper forms, nearly all transactions are now done

electronically. This means that services are entered into your software system to be used in your billing process. Working with a billing service or another LHD to do your billing may be the best choice for you: If you serve a lot of clients, have limited staff and time, currently do not bill for any services. Many of you already bill Medicaid and Medicare and are ready to add private insurance billing. So, you may want to work with a billing clearinghouse. A clearinghouse is a company that will check to see if your claims have any formatting errors and send them to private insurance companies for you. Clearinghouses and billing vendors offer a variety of billing services.

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 what the health care provider did are called CPT® codes. There are two types of CPT® codes used by providers: evaluation and management codes and procedure codes.

Evaluation and management codes are used to describe the general patient visit. 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 the local health department should be compensated. Appropriate CPT codes must be billed with the GT or 95 modifier for telehealth.

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 every possible medical problem. HCPCS codes use alpha and numeric characters to describe some drugs.

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding system does not designate specific billing codes for PrEP or PEP related services. Since there are no official billing codes specifically for PrEP (pre-exposure prophylaxis), listed here are ICD-10-CM and CPT codes that can be used and are highly recommended by experienced PrEP providers.

Category	Billable ICD-10	Description
Contact with and (suspected) exposure to communicable diseases†	**Z20.6**	Contact with and (suspected) exposure to HIV
	Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
	Z20.89	Contact with and (suspected) exposure to other communicable diseases
	Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
High-risk sexual behavior	**Z72.51**	High-risk heterosexual behavior
	Z72.52	High-risk homosexual behavior
	Z72.53	High-risk bisexual behavior
Other hazardous exposures	**Z77.21**	Contact with and (suspected) exposure to potentially hazardous body fluids
	Z77.9	Other contact with and (suspected) exposure hazardous to health
Contact with hypodermic needle	**W46.0XXA**	Contact with hypodermic needle (initial enc.)
	W46.0XXD	Contact with hypodermic needle (subsequent enc.)
	W46.1XXA	Contact with contaminated hypodermic needle (initial enc.)
	W46.1XXD	Contact with contaminated hypodermic needle (subsequent enc.)
Long-term prophylaxis	**Z79.899**	Other long-term (current) drug therapy

CPT	Description
99401	Prevention Counseling (15 minutes)
99402	Prevention Counseling (30 minutes)
99403	Prevention Counseling (45 minutes)
99404	Prevention Counseling (60 minutes)

All visits must include a “principal diagnosis/first-listed condition” to be billable. Z20.6, bolded above, is classified as an “acceptable principal diagnosis” in the ICD-10-CM system. Always include Z20.6 when coding PrEP visits. If an insurer requires additional code clarifying a patient’s risk, Z20.2 (sexual exposure risk) and F19.20 (injection drug use exposure risk) can be added. These codes avoid the use of the Z72.x codes that are considered stigmatizing because they indicate “problems related to lifestyle.” HIV, STD, HCV and other tests associated with PrEP are related to the patient’s ongoing risk of infection, even if the patient is asymptomatic. Screening tests are ordered at initial visit. Subsequent visits use ‘contact with’ codes. Tests which are ordered to evaluate the patient for conditions potentially associated with long-term

use of PrEP medication should include the code Z79.899. Listed below are PrEP related codes based on visit type.

PrEP-related Codes – Initial Visit		
Coding for:	**ICD-10 Code**	**Description**
Visit	**Z20.6**	**Contact with and (suspected) exposure to HIV**
	Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Initial Tests	Z01.812	Encounter for pre-procedural laboratory examination (Applicable to blood and urine tests prior to treatment or procedure)
	Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
	Z11.4	Encounter for screening for human immunodeficiency virus
	Z11.59	Encounter for screening for other viral diseases*
PrEP-related Codes – 2nd and Subsequent Visits		
Coding for:	**ICD-10 Code**	**Description**
Visit and Tests	**Z20.6**	**Contact with and (suspected) exposure to HIV**
	Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
	Z79.899	Other long term drug therapy
	Z20.5	Contact with and (suspected) exposure to viral hepatitis*

You can submit your claims in a number of ways. Print the claims on CMS-1500 paper forms and mail, fax, or email them. Paper claims are rarely accepted anymore. Claims can be submitted using an electronic file transfer that can be uploaded to a website or another program. Claims can also be entered by submitting the billing information online, through the insurance company website, a vendor or a clearinghouse website. Also, there are direct data entry allowed into the insurance carrier's website or into the clearinghouse website, where the clearinghouse can pass the claim directly to the insurance carrier.

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

- Taxonomy code
- Taxpayer Identification Number
- National Provider 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. The taxonomy code lookup is 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 does not 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 does not 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.

Telehealth HIV-PrEP Documentation

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-PrEP sessions should be as thoroughly documented as all other patient/client encounters. Records should minimally 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-PrEP 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.

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.

Appendices

Acronyms

ACA	Affordable Care Act
AMA	American Medical Association
BCBS	Blue Cross Blue Shield
CMS	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
PCP	Primary Care Provider
PEC	Pre-existing Condition
PHI	Protected Health Information
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
RA	Remittance Advice
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 software 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 patient's insurance plan, that 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, 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 a 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 number 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 code 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. (CAQH are the initials of the Council for Affordable Quality Healthcare, Inc.; see CAQH.org for more information).

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 – The amount a 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 a 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 noted by 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. 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. CPT is Level I.
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. Establishes 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. Patient is 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 must 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, but still provides some coverage for out-of-network providers.
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 patient's insurance company to determine the, medical necessity for the services proposed or rendered. This does not guarantee that 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 just before the patient's effective date of coverage. A pre-existing 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, a reference to the difference between what the physician charges and what the insurance plan contractually allows, and which the patient is not responsible for. May also be referred to as "not covered" in some glossary of billing terms.

Resources

CDC website: http://www.cdc.gov/hiv/prevention/research/prep/

San Francisco City Clinic's website: http://www.sfcityclinic.org/services/prep.asp

New York State DOH patient ed: http://www.nyc.gov/html/doh/html/living/prep-pep.shtml

New York State clinical guidelines: http://www.health.ny.gov/diseases/aids/general/prep/#prep

Project Inform patient education: http://www.projectinform.org/prep/

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

https://www.descovy.com/prep/what-is-descovy-for-prep?utm_medium=cpc&utm_campaign=USA_GO_SEM_NB_EX_Descovy-DTP-Learn+About+A+Gilead+Medication-PrEP-Standard&utm_content=PrEP_General&utm_term=prep+for+hiv+prevention&utm_source=google&gclid=CjwKCAiAlNf-BRB_EiwA2osbxeCSXHsGLVowYujnGk3vIpDXuli8xj1NTYjYzwo-0Cfn3iAXHs00gxoC03UQAvD_BwE&gclsrc=aw.ds

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

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

https://www.jeffersoncountypublichealth.org/DocumentCenter/View/1926/Washington-State-Local-Health-Jurisdiction-Immunization-Billing-Resource-Guide-PDF

https://www.mayoclinic.org/diseases-conditions/hiv-aids/expert-answers/prep-hiv/faq-20456940

https://plushcare.com/prep-online/?utm_source=google&utm_medium=cpc&utm_campaign=LS_PrEP_BMM&gclid=CjwKCAiAlNf-BRB_EiwA2osbxThjs4HPDe5Z5Fl1BkWsTKpab6Eqvu87-t7m6oQ3ONCHZ2kBpE0R8BoCVXQQAvD_BwE

https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30183-3/fulltext

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