HEALTH MANAGEMENT ASSOCIATES

Maximizing Insurance Payment for Covered HIV/STI Services

Prepared for Oregon Health Authority, Public Health Division, HIV/STD/TB Section

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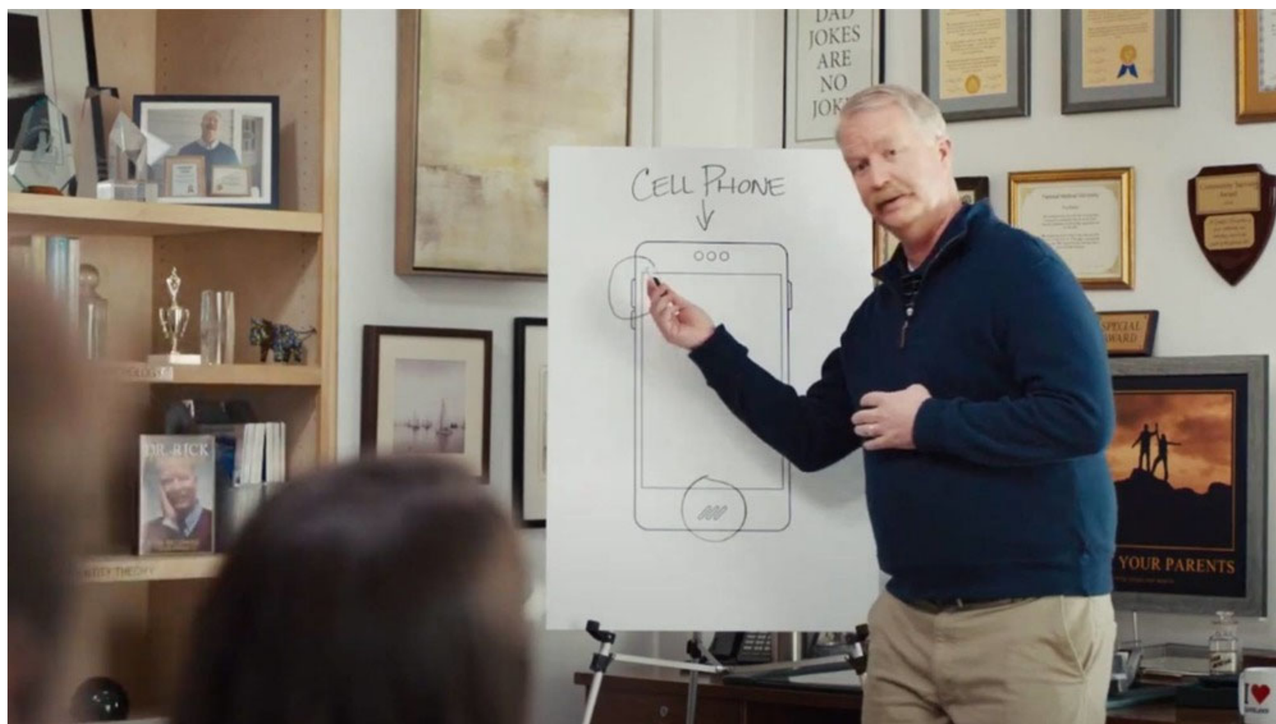
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JOKES
ARE
NO
CELL PHONE
DR. RICK
YOUR PARENTS

LEARNING OBJECTIVES

This webinar will cover the impact of key regulatory constraints and business processes of payers (insurance companies) relative to HIV/STI billing, including:

- Review of what HIV/STI Services are billable and under what conditions
- Understanding client eligibility, cost sharing, and EOBs
- CCO obligations related to reimbursement for point of care services and partnerships with LPHAs
- Essential Health Benefits and USPTSF
- Impact of provider types on payments policies including impact of independent licensure status and full prescriptive authority
- Diagnosis and Procedure Codes

AGENDA

- Brief Overview of Process
- Summary of Findings
- EISO Services and Billing Including Technical Requirements
  - Coding
    - *(Are the diagnoses and procedure codes appropriate?)*
  - Provider Type
    - *(Is the provider allowed to bill for the service?)*
  - Benefit Determination
    - *(Is the service covered?)*
  - Fee Schedule
    - *(Is there an associated payment amount on the OHP fee schedule?)*
- CCO Obligations and Billing Opportunities
- Wrap Up and Next Steps

EVALUATION PROCESS

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HIV/STI PROJECT OVERVIEW

Provider Assessment - Online survey followed by one-on-one interviews to understand:

- EISO Provider and Partner's Service Models
- Insurance and Payer Relationships
- Billing Infrastructure
- Health and Equity Impacts

Payer Assessment – Research and one-on-one interviews to understand:

- Policies, Processes, and Requirements
- Relationships with Current EISO and LPHA Providers and Partners
- Coding Analysis of Services Provided

Oregon State PH Laboratory – Data review and one-on-one interviews to understand:

- Policies, processes, and requirements
- Relationships with current payers

Note: While we included all payer types in our evaluation and assessment, we are restricting the billing proposal to clients covered by the Oregon Health Plan whether they are enrolled in a CCO or are Open Card.

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FINDINGS

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HIV/STI PROVIDER ANALYSIS: FINDINGS – GAPS AND CHALLENGES

HMA identified **six key gaps and challenges** that must be addressed to advance billing for HIV/STI Services

1. **Misinformation/lack of information**
2. **Low barrier model**
3. **Client confidentiality**
4. **Cost (cost-sharing or billing)**
5. **Staff/organizational capacity impacts**
6. **Is the juice worth the squeeze**

HIV/STI PROVIDER ANALYSIS: FINDINGS – SUCCESSES AND STRENGTHS

In addition to identifying gaps or challenges, we also identified **two significant successes and strengths**

1. Existing infrastructure

- Almost all HIV/STI Providers had existing and extensive insurance billing infrastructure and capacity in other parts of their organizations that could be leveraged for billing HIV EISO services provided by public health. This infrastructure often included:
  - Policies, procedures, and workflows for collecting and billing insurance
  - Existing contracts with public and private payers
  - Information technology infrastructure
  - Staffing

2. Experience billing for other PH services

- We found examples of public health using their county's clinical services billing infrastructure to bill for other public health services like nurse home visiting and immunizations.
- Some county public health departments are currently billing CCOs for immunizations and family planning services *without* a clinical partner.

REGULATORY FINDINGS: AFFORDABLE CARE ACT, OREGON STATUTE AND RULE, CCO CONTRACTS

COVERAGE

ESSENTIAL COMMUNITY PROVIDERS (ECPs)

ESSENTIAL HEALTH BENEFITS (EHBs)

PAYMENT FOR SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENTS

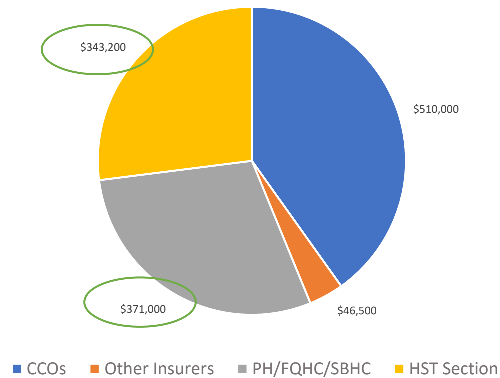
OHA CONTRACT WITH CCOs

CODING ANALYSIS

FINDINGS: OSPHL

SUMMARY

- In fiscal year 2020, OSPHL collected $1.3 million for HIV/STI testing from payers and providers.
- OSPHL relies on the agency submitting the specimen to identify whether the client is covered by OHP.
- Billing CCOs or OHA for all clients covered by the Oregon Health Plan could reduce the payment burden on the HST Section, other public health agencies, School Based Health Centers, and FQHCs.



EISO SERVICES AND BILLING

CODING ANALYSIS

Each of the EISO Service Categories were evaluated by a certified coding firm to evaluate and identify the following critical components for successful billing:

- valid and applicable diagnosis and services codes,
- which provider types are allowed to bill for the services,
- whether the benefits were determined to be covered, and
- whether there is an associated payment amount in the OHA fee schedule.

DIAGNOSIS AND SERVICE CODE DETERMINATION

HIPAA requires providers and health plans to use standard content, formats and coding for health care transactions.

According to the Centers for Medicare and Medicaid Services (CMS) the three main codes sets used in healthcare are ICD-10-CM, CPT, and HCPCS Level II.

- ICD-10-CM is used to report medical **diagnoses** on claims for services provided. Codes are chosen according to what is documented in the patient's medical record. The Center for Disease Control and Prevention developed and maintains this code set.
- CPT is used by providers to report **medical procedures and professional services** provided in outpatient and ambulatory setting, including physician visits to inpatients. The American Medical Association (AMA) developed, copyrighted and maintains this code set. (Sometimes called HCPCS Level I).
- HCPCS are codes and modifiers that **mainly identify products, supplies, and services not included in the CPT codes**, such as ambulance services, drugs, devices, prosthetics, orthotics, durable medical equipment, and supplies. CMS maintains this code set. (Sometimes called HCPCS Level II).

CODING DETERMINATION – COMMON DIAGNOSIS CODES FOR EISO SERVICES

ICD-10	Description	Use For
Z01.812	Encounter for pre-procedural laboratory examination	Use for blood or urine tests prior to treatment
Z11.3	Encounter for infections with a predominantly sexual mode of transmission	STI Screening
Z11.4	Encounter for screening for human immunodeficiency virus	HIV Screening
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV STI Screening
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	HIV Screening
Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
Z72.51	High risk heterosexual behavior	HIV, STI screening
Z72.52	High risk homosexual behavior	HIV, STI screening
Z72.53	High risk bisexual behavior	HIV, STI screening

CODING DETERMINATION – COMMON CPT/HCPC CODES USED FOR EISO SERVICES

CPT Code	Description
99201 - 99205	Office or other outpatient visit for evaluation and management of a new patient
99211 – 99215	Office or other outpatient visit for evaluation and management of an established patient
99401 – 99404	Preventive medicine counseling and/or risk factor reduction interventions provided to an individual (15 – 60 minutes)
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	See above, 2 – 4 patients
98962	See above, 5 – 8 patients
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.
96156 - 96171	Health Behavior Assessment and Intervention (HBAI) are to report assisting patients to overcome emotional / social barriers to their physical disease management and self-management of chronic disease. These codes address a wide range of physical health issues, including HIV.

ALLOWABLE PROVIDER TYPES

Provider Type:

- Classifies providers according to the type of license or accreditation they hold. Examples include physicians, nurse practitioners, hospitals, laboratories, dentists, pharmacists, registered nurses, and community health workers.
- For EISO insurance billing purposes, the critical determination of whether a provider is allowed to bill for certain services can be summarized as (1) can they diagnose and (2) can they order or provide treatments.
- There is a highly regulated system to identify the various types of providers based on a taxonomy code managed by X-12, a quasi-governmental organization that manages coding sets for all types of insurance transactions.
- It is critical to understand that even though a provider can deliver a service, it doesn't mean the insurance companies will pay for it.
- Many practices use a system of standing orders to leverage the skills of different types of providers and staff but still allow for insurance coverage. These services are billed under the provider who orders the service.

ALLOWABLE PROVIDER TYPES – TAXONOMY CODE EXAMPLE

Provider Specialty	Taxonomy Code	Washington Publishing Company Taxonomy Code Detail (www.wpc-edi.com/taxonomy)	BCBSM Internal Provider Specialty	BCBSM Internal Provider Type(s)
Adult Care Nurse Practitioner	363LA2200X	Physician Assistants and Advanced Practice Nursing Providers – Nurse Practitioner – Adult Health	W1	RNC/CLN
Adult Psychiatric Mental Health Nursing	364SP0809X	Physician Assistants and Advanced Practice Nursing Providers – Clinical Nurse Specialist – Adult Psychiatric/Mental Health	W7	RNC/CLN
Allergy and Immunology	207K00000X	Allopathic and Osteopathic Physicians – Allergy and Immunology	03	MD/DO/CLN
Ambulance Company	341600000X	Transportation Services – Ambulance	59	AMB
Ambulatory Health Care Facility	261QR0200X	Freestanding Radiology Centers	30	FRC
Ambulatory Surgical Center	261QA1903X	Ambulatory Health Care Facilities – Clinic/ Center – Ambulatory Surgical	49	AMS
Anesthesiology	207L00000X	Allopathic and Osteopathic Physicians – Anesthesiology	05	MD/DO/CLN

IDENTIFIED BILLING OPPORTUNITIES

Service	Billing Opportunity
Education, Information, and Referral	Under provider orders by a CHW
Screening/Evaluation	Included with Office Visit
Testing & Diagnosis	Under standing orders by lay staff
Treatment	Included with Office Visit
Counseling	Under provider orders by a LCSW, LMHP, etc.
Case Investigation and Partner Svcs	Included with Office Visit
Monitoring PLWHA	Licensed clinician including RN
Targeted Case Management	Dependent on county-specific programs

COVERED BENEFITS & BENEFIT DETERMINATION

Coverage Determination

- The decision on whether a medical care item or service is a covered benefit. Coverage determinations may be appealed under rules set forth by state law and ACA.

Covered Benefits

- The medical care items or services obtained by a subscriber that a health insurance plan agrees to pay for, under certain terms and limitations. Covered benefits and excluded services, and the terms and limitations of coverage, are defined in the health insurance plan's coverage documents or the subscriber contract.

Exclusions

- Lists of specific medical items or services or general circumstance (e.g., not medically necessary) in a subscriber contract that are not covered benefits.

Medical Management Systems

- Systems designed to ensure that members receive appropriate [covered] health care services. Medical management systems include, but are not limited to, utilization management, quality improvement, case management, and complaint resolution.

COVERED BENEFITS & BENEFIT DETERMINATION

Medical Necessity Determination

- A specific type of coverage determination about whether a medical item or service, which is a covered benefit, is medically necessary for an individual patient's circumstances, and thus a covered benefit. Typically, this determination is made by the insurer.

Medically Necessary

- A condition of benefit coverage frequently found in subscriber contracts. Under the terms of most subscriber contracts, the receipt of a medical care item or service does not in and of itself indicate that the item or service was medically necessary.

COVERED BENEFITS & BENEFIT DETERMINATION

AFFORDABLE CARE ACT COVERAGE REQUIREMENTS

- Ban on denying coverage due to pre-existing conditions
- Prohibits annual/lifetime (financial) benefit caps
- Provided subsidies to make insurance more affordable
- Extended dependent coverage to age 26
- Expanded Medicaid to more individuals with low incomes
- Required all "ACA" populations to have coverage for 10 Essential Health Benefits

ESSENTIAL HEALTH BENEFITS

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- MH/SUD services and treatment
- Prescription drugs
- Rehabilitative/habilitative services
- Laboratory services
- Preventive and wellness services
- Pediatric services, plus oral & vision

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

EHB RELEVANCE FOR EISO SERVICES

EHBs are especially important for people living with HIV/AIDS and people with or at risk for sexually transmitted infections:

- Health plans subject to these regulations must cover "medically necessary" HIV and STI testing and may cover routine HIV testing regardless of risk. As of 2015, 42 states, including Oregon, and DC report requiring Medicaid plans, QHPs, and other health plans regulated by the State to cover routine HIV testing. (The remaining eight only cover medically necessary testing.)
- States must also cover pre-exposure prophylaxis (PrEP), the drug used to prevent HIV among those disproportionately impacted by HIV
- Under the ACA, state Medicaid programs are incentivized to cover a full suite of preventive services, including routine HIV testing and PrEP (starting in 2021), without cost-sharing in exchange for a 1% increase in the federal matching rate for those services. Oregon is one of 15 states that has been approved for this increase in exchange for offering these services without cost-sharing, so CCOs do not require prior-authorization for HIV prevention services.

OHP FEE SCHEDULE, PAYMENT AMOUNTS (AND CCO PAYMENTS)

"The OHP fee schedules are informational only. Because many factors influence payment, inclusion of a rate in the fee schedule does not guarantee payment. Rates may change without notice."

If the code is on the OHP Fee Schedule:

- it may or may not have a payment amount associated with it,
- if there is no payment amount, it is usually not covered,
- if the code has an associated payment amount, it may or may not be covered for the type of services you provide,
- CCOs typically use the fee schedule as the minimum amount they will pay, and
- providers who are credentialed and contracted with the CCOs may get paid more than the OHP fee schedule.

OPPORTUNITIES

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OREGON STATUTE AND RULE REQUIRES CCOs TO PAY FOR MOST OF THE EISO SERVICES

PAYMENT FOR SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENTS

- The governing statute for Services Provided by Local Health Departments as it relates to CCOs is found in ORS 414.153 and is summarized below:
  - Unless cause can be shown why such an agreement is not feasible, require and approve agreements between coordinated care organizations and publicly funded providers for authorization of payment for point of contact services (described below).
  - Encourage and approve agreements between coordinated care organizations and publicly funded providers for authorization of and payment for services in the following categories:
    - (a) Maternity case management;
    - (b) Well-childcare;
    - (c) Prenatal care;
    - (d) School-based clinics;
    - (e) Health care and services for children provided through schools and Head Start programs; and
    - (f) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups
- OAR 410-147-0080(6) requires CCOs to have agreements in place with publicly funded providers to allow payment for point-of-contact services including:
  - immunizations,
  - sexually transmitted diseases and other communicable diseases,
  - family planning,
  - HIV/AIDS prevention services.

CCO CONTRACTS INCLUDE REQUIREMENTS TO COVER THESE SERVICES

OHA CONTRACT WITH CCOs

- Since 2012, primary components of the CCO global budgets and shared accountability arrangements have included Medicaid-funded public health services.
- CCOs are required to enter into Memorandums of Understanding with LPHAs, LMHAs, and AAA/APD agencies in their service area(s).
- CCOs are required to follow the requirements found in ORS 414.153 and OAR 410-141-3705(7)(a-b) as described in more detail above
- Annual reports of the CCO's cooperative agreements with publicly funded programs are required to identify which programs the CCO has relationships with.
- Most CCOs reported regularly receiving and paying claims from their public health departments and all CCOs said they would gladly pay for all point of contact services described in statute and rule.
- The contract requires the CCO to treat the OSPHL as a contracted provider regardless of whether there is a contract in place.

POTENTIAL BILLING OPPORTUNITIES

Each of the following Service Categories were evaluated and a coding determination was made, including the allowable provider type and whether there is an associated payment amount in the OHA fee schedule:

Service	Billing Opportunity
Education, Information, and Referral	Under provider orders by a CHW
Screening/Evaluation	Included with Office Visit
Testing & Diagnosis	Under standing orders by lay staff
Treatment	Included with Office Visit
Counseling	Under provider orders by a LCSW, LMHP, etc.
Case Investigation and Partner Svcs	Included with Office Visit
Monitoring PLWHA	Licensed clinician including RN
Targeted Case Management	Dependent on county-specific programs

BILLING OPPORTUNITY: TRADITIONAL/COMMUNITY HEALTH WORKERS

- The American Public Health Association defines a Community Health Worker as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This definition aligns very closely with many of the direct service providers in the EISO grant funded projects.
- To qualify for reimbursement, CHWs must be certified by the OHA and enrolled in the State's central registry.
  - CHWs must complete 80 hours of training from an approved training program and meet required competencies to become certified.
  - CCOs can collect the names of CHWs from contracted entities and validate their certification in the State's registry. CCOs also report the names of CHWs as contractually required when reporting network adequacy to OHA.
  - Costs for training programs to achieve certification average $1,100.
  - The CHW must obtain a unique National Provider Identifier (NPI) and enroll as a "non-payable rendering provider" in Oregon Medicaid.
  - When a CHW is the rendering provider, OHA or the CCO will allow the code to be paid. The billing provider must be a clinic or supervising medical provider. Many of the EISO services are eligible for CHW billing codes including those summarized below, and the CHW Billing Guide.

BILLING OPPORTUNITY: TRADITIONAL/COMMUNITY HEALTH WORKERS

To be eligible for payments with Medicaid funds, either directly from OHA or via CCOs, a licensed provider must order the services and must order that they be provided by a CHW.

Code	Rate	Description
99401	$27.50	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	$45.51	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	$62.43	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	$79.94	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
98960	$18.78	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	$9.02 per patient	(see 98960); for 2-4 patients
98962	$6.56	(see 98960); for 5-8 patients

BILLING OPPORTUNITY: ADDITIONAL SERVICE CATEGORIES ELIGIBLE FOR BILLING

SERVICE CATEGORY	STD/HIV ACTIVITY DEFINITION	PAYABLE CODES	ELIGIBLE PROVIDER TYPE	ALLOWED AMOUNT
Testing & Diagnosis	Provide STD and HIV testing as well as any additional testing required to confirm a diagnosis	Payable to Reference Lab	If seen by a licensed provider on the date of the specimen collection or collected under a standing order, can be collected by anybody trained to draw the specimen.	See OSPHL Fee Schedule
		Payable to Clinician collecting specimen: Venipuncture 36415		$2.10
Counseling	Counsel patient/partners about reducing their risk for acquiring or transmitting infection to others. Refer them for additional prevention services, if needed.	G0445 96156 - 96159	G0445 must be provided by physician, NP, or PA HBAI can be provided by a QMHP, LCSW, or LPC	$19.28 (G0445) Assessment $68.96 Intervention $47.15/$16.64 Group Intervention $6.96/$3.27
Monitoring PLWHA	Patient follow up for recommended re-testing per CDC and OHA guidance	Chronic Care Case Management Services w/o Patient Visit (generally non-face-to-face): 99487 - 99491	Must be billed under: Physician, Nurse Practitioners, Physician Assistant, Nurse	Complex $63.22 Add'l 30 Min $30.62 Chronic 20 min $31.48 Chronic 30 min $57.66

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Created a Billing and Coding Toolkit

The Billing and Coding Toolkit can be found here:

https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/SEXUALLYTRANSMITTEDDISEASE/Documents/HIV_STI_Billing_Toolkit.pdf

EISO Contract Language Regarding Billing is Changing

The current contract language requires grantees to get permission from OHA to bill for services and specifies that revenue generated from billing must be returned to the program.

Watch for an Upcoming Learning Collaborative

Planning is underway for a learning collaborative for LPHAs and other partners that are successfully billing for HIV/STI services to share best practices.

Update and Enforce CCO Contracts

Current CCO contracts do not include language enforcing the regulations that require CCOs to contract with LPHAs for certain point of care services. OHA should remedy this during the next contract amendment process and ensure that it is enforced.

OSPHL Can Check MMIS for Medicaid Coverage

Since the CCOs do not issue EOBs or any other type of communication specific to services rendered, there could be more revenue collected from the CCOs simply by checking MMIS for eligibility. This type of eligibility inquiry is highly automated and rarely presents a labor burden.

Increase OSPHL Fee Schedule to Maximum Allowed Amount for Commercial Payers

OSPHL should ensure they are billing commercial payers the maximum allowed amount under those contracts.

Leverage Existing Infrastructure

If a public health agency is already billing for other public health services, or a related FQHC is billing for clinical services, the LPHAs should leverage the billing infrastructure and best practices already in place in other parts of their agencies.

Maximize E&M Codes for Licensed Providers

Licensed providers (physicians, nurses, advance practice providers) in public health agencies could bill E&M codes for certain counseling and other services rendered as part of HIV/STI diagnosis and treatment to their full extent.

Hire Certified Community Health Workers

Certified CHWs can bill Medicaid for some services in community settings. HIV/STI partners could hire certified CHWs or support currently employed staff in becoming certified CHWs.

Advocate for Suppression of EOBs for HIV/STI Services

HIV/STI Providers could start a policy conversation about implementing laws to require state-regulated commercial insurers to suppress EOBs for certain procedures related to sexual health.

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