Maximizing STI Reimbursement in Maryland
Billing Tools, Tips and Resources
December 3, 2014

PRESENTED BY:

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Maryland Department of Health and Mental Hygiene
Objectives

Understand Relevant Maryland Reimbursement Issues

Understand STI Coding, Documentation and Revenue Cycle Management

Learn How to Avoid Common Reimbursement Pitfalls
# Non-Chargeable List –2015 (State Fiscal Year)

<table>
<thead>
<tr>
<th>Infectious Disease Services (included here, only those related to STIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STI Diagnosis and Treatment</strong></td>
</tr>
<tr>
<td><strong>STI Outreach</strong></td>
</tr>
</tbody>
</table>
| **Infectious Disease Testing** | *STI services provided:*
  -- in the course of an outbreak;
  -- to contacts/sex partners, as defined by Local Health Officer/Health Commissioner |
Confidential Communications Request Form

SENATE BILL 790 (Chapter 72) – Health Insurance - Communications Between Carriers and Enrollees - Conformity with the Health Insurance Portability and Accountability Act (HIPAA)

• Requires the Insurance Commissioner to develop and make available a standardized form for an enrollee to use to request confidential communications from an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization. A carrier that requires an enrollee to make a request for confidential communications in writing must accept the standardized form.

• Permits a carrier to accept any other form of written request from an enrollee for confidential communications from a carrier under the HIPAA privacy rule.

• Specifies that certain written notices from an insurer to a claimant regarding denial of a claim made under an individual health insurance policy and annual summary explanations of benefits provided to an insured are subject to confidential communications requirements under the HIPAA privacy rule.

Effective Date: April 8, 2014

Source: Maryland Insurance Administration Bulletin 14-17, June 16, 2014
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

FORM

If you are covered under a health insurance policy, and you could be endangered by the disclosure of your protected health information through a health insurer’s communication to the policyholder or certificate holder, this form allows you to request that communications of your protected health information from your insurer be sent by alternative means or to an alternative location.

Policyholders (or certificate holders for group contracts) receive information about the health care services received by family members and dependents covered under their policy. So, if your spouse, partner, or parent is the policyholder or certificate holder, this information may be sent to them. Examples of the most common information sent by insurers are “Explanation of Benefits” forms, and claim denial letters.

Before submitting this form to your insurer, you may wish to contact your insurer to determine if it permits a request to be taken over the phone or by e-mail. If the insurer requires a written request, please complete this form and submit it to your insurer.

NOTE: If your insurer grants your request, it will affect only written and oral communications with that insurer. After you submit this form, check back with your insurer to make sure your request has been processed and approved. Until that time, the insurer may continue to send information to the policyholder or certificate holder. You will need to contact the employer, other insurers, and each of your health care providers, separately to request that they not send any confidential communications to the policyholder or certificate holder.

Verification- (Please print)

The following information is needed to identify you:

Insurance Company Name: ________________________________

Your Name: ____________________________  Last Name  First Name  Middle Name

Date of Birth: ________________________________

Name of the Policyholder or Certificate Holder: ________________________________

Address of Policyholder or Certificate Holder: ________________________________
Sliding Fee Scale

Uninsured *(self-pay)* and Underinsured Patients

- **Proof of income** (Family Planning Programs to follow Title X Guidelines)
  - Recent pay stub
  - Notarized letter from the person who supports the Client
  - Information obtained from other LHD departments
  - Income tax forms
  - W-4

Each LHD should define in a written policy what they require for proof of income
NO CLIENT SHOULD BE TURNED AWAY FOR INABILITY TO PAY
Contracting
Credentialing
Payer Reimbursement
Participating (In-Network) Provider

- a health care provider that has an agreement with a health plan to accept their members at an agreed upon contracted rate

Non-participating (Out-of-Network) Provider

- a health care provider that has not contracted with a health plan and does not agree to accept the network contracted rate
STI services are not Self-referred services

Contract for maximum reimbursement

Medicare Medicaid MCO

Commercial Payers
How do we become In-Network?

Commercial payer contracts must be approved by the Office of the Attorney General ("OAG"), the Secretary of the Department of Health and Mental Hygiene, and the governing body of the county in which the health department is located.

United Health Care statewide contract should become effective in the next few months for only those LHDs that have met the credentialing and signed-on requirements.

CareFirst’s legal contract terms were finalized and each LHD has access to their contracting materials.
Can we bill Medicaid for a service that is provided free of charge to an uninsured client?

- Medicaid cannot be charged unless the patient and payers are also charged. *(if you are not contracted a payer you are not required to send a “claim to that payer”)*

- Medicaid cannot be charged more than what is charged to other payers and patients.

- Uninsured patients can be charged based on the sliding-fee scale.
We cannot bill MCO's because we are not an IN-NETWORK provider, can we charge Medical Assistance clients on sliding scale fee?

No

Medicaid Patients cannot be charged
Contracting with Medicaid Managed Care Organizations (MCO)

State Providers’ Amendment To Healthchoice Provider Service Agreements

DHMH regulations and MCO provider manuals require LHDs to have certain written procedures in place before they can contract as MCO service providers.
Payer Credentialing

Most health plans in Maryland required the LHDs to credential providers individually (rather than credentialing the entire LHD as a whole).

Providers should be in the process of completing their CAQH applications in order to be credentialed with United.

Most Commercial and Managed Care Organizations use the CAQH application for credentialing.

CAQH: The Council for Affordable Quality Healthcare
Contracted - NOW WHAT?

Information regarding health plan procedures and policies can be found in the plans’ provider manuals, and those manuals must be reviewed by pertinent LHD staff.

It is very important to comply with the procedures outlined in the provider manuals. If proper procedures for claim submission are not followed, claims will likely be denied, and the LHD will be prohibited from charging the patient.
Charge Setting Regulations – Payer Reimbursement

Charges for LHD services are set pursuant to Title 16 of the Health-General Article of the Maryland Code and COMAR 10.02.01.

DHMH and the LHDs are looking at a number of changes to the charge setting regulations. Those changes include altering the method for setting costs and clarification of the application of the sliding fee scale.

Health plan reimbursement is based on contracted rates and may be different than the LHD fee schedule. Reimbursement may be reduced if the client has a co-pay or deductible.

Continue to apply the sliding fee scales in the manner that you have in the past, until further guidance is issued.
## Types of Commercial Payer Plan Types

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indemnity Plan</strong></td>
<td>A traditional indemnity plan allows the patient freedom in choosing their providers, usually with no (or minimal) restrictions.</td>
</tr>
<tr>
<td><strong>Fee-for-Service Plan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>High Deductible Health Plans</strong></td>
<td>These plans have high deductibles, ($1,000 to more than $10,000) but have much lower premiums than traditional insurance.</td>
</tr>
<tr>
<td><strong>Health Maintenance Organizations (HMOs)</strong></td>
<td>HMO plans typically require the patient select an in-network primary care provider. May require the patient to obtain a referral to see a in-network specialist. These plans cost less, but limits the patients choice.</td>
</tr>
</tbody>
</table>
The PPO plan uses a network of preferred providers for access to a range of health services at reduced prices. The patient can see an out-of-network provider but will have a higher out-of-pocket expense.

These plans allow the patient to see out-of-network providers but the patient will have higher a out-of-pocket expense, such as a higher copay and deductible. Patients will pay a higher premium for the out-of-network option.

Is a group health plan established/maintained by an employer or employee organization (such as a union - as an employee welfare benefit plan), that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.
Payer Tools, Tips and Resources

- **Know your payers**
  - Administrative manual
  - Program manuals
  - Policies – pre-authorization requirements
  - Sign-up for payer newsletters and provider bulletins
  - Payer fee schedules and claim management tools
  - Sign-up on the payer provider portal
- Establish communications and relationships with payer provider representatives
## Maryland Managed Care Organizations (MCOs)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMERI GROUP Community Care</td>
<td><a href="http://www.amerigroupcorp.com">www.amerigroupcorp.com</a></td>
</tr>
<tr>
<td>Jai Medical Systems</td>
<td><a href="http://www.jaimedicalsystems.com/">http://www.jaimedicalsystems.com/</a></td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td><a href="http://maryland-medicaid.kaiserpermanente.org/healthchoice.html">http://maryland-medicaid.kaiserpermanente.org/healthchoice.html</a></td>
</tr>
<tr>
<td>Maryland Physicians Care</td>
<td><a href="http://www.marylandphysicianscare.com/">www.marylandphysicianscare.com/</a></td>
</tr>
<tr>
<td>MedStar Family Choice</td>
<td><a href="http://www.medstarfamilychoice.net">www.medstarfamilychoice.net</a></td>
</tr>
<tr>
<td>Priority Partners</td>
<td><a href="http://www.ppmco.org/">www.ppmco.org/</a></td>
</tr>
<tr>
<td>Riverside Health</td>
<td><a href="http://www.myriversidehealth.com/ForProviders.aspx">http://www.myriversidehealth.com/ForProviders.aspx</a></td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td><a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a></td>
</tr>
</tbody>
</table>
Coding for STI Services
Accurate Coding is **Key** to:

- Substantiating patient caseload intensity and complexity
- Optimizing patient service revenue
- Making medical equipment and supply purchase decisions
- Improving communication among medical clinicians and administration
Good Documentation is **Key** to:

1. Ensuring high quality patient care
2. Reducing the risk of audit recovery
3. Demonstrating medical necessity, the principal criteria for payment
### Evaluation & Management (E/M) Services

E/M coding is the process by which physician-patient encounters are translated into five digit CPT codes to facilitate billing.

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td>All Problem-oriented Medical Care</td>
</tr>
<tr>
<td>Outpatient Hospital Visits</td>
</tr>
<tr>
<td>Consultation Services</td>
</tr>
<tr>
<td>Inpatient Medical Care</td>
</tr>
<tr>
<td>Emergency Room Care</td>
</tr>
</tbody>
</table>
Public Health utilizes two (2) categories of CPT codes used to report E/M Services:

**New Patient Visits**
- CPT codes 99201-99205

**Established Patient Visits**
- CPT codes 99211-99215
New Patient vs. Established Patient

**New patient** = A patient that has never been seen by a provider in the Health Department; or has not been seen by any provider in the Health Department within the last 3 years

**Established patient** = A patient that has been seen by a provider or had services performed in the Health Department within the last 3 years
Outpatient services have five (5) designated levels.

New patient levels do not crosswalk to established patient levels.
All E/M Services have three (3) components:

- History
- Physical Exam
- Medical Decision-Making
All E/M services are determined by the level of criteria met within each component.
Four (4) Levels per Component:

History and Physical Exams

- Problem-focused
- Expanded Problem-focused
- Detailed
- Comprehensive
Four (4) Levels of Medical Decision-Making

\{ Straightforward \} \{ Low Complexity \} \{ Moderate Complexity \} \{ High Complexity \}
Your documentation must meet or exceed the level coded in all three components for new patient visits.

Lowest key component sets level of service.

This applies to consultation services and other initial E/M services.
2 out of 3

Your documentation must meet or exceed the level coded in two out of three components for *established* patient visits.

Lowest key component can be ignored.
Patient History - *Drives Medical Necessity*

Has three (3) components in addition to the **Chief Complaint (CC):** (Chief complaint is documentation for the reason of the patient visit in the patient’s own words.)

- **History of Presenting Illness (HPI):** (HPI is the narrative of how the complaint condition developed)
- **Past Medical, Family and Social History (PMSFH)**
- **Review of Systems (ROS)**
History of Presenting Illness (HPI): Qualifiers

- Location (Ex: exposure site - genital, anal, oral - all that apply)
- Quality (Ex: aching, burning)
- Severity (Ex: 7 on a scale of 1-10)
- Timing (Ex: date of last exposure)
- Duration (Ex: amount of time sexually active w/ partner)
- Context (Ex: partner - male/ female)
- Modifying Factors (Ex: condoms used; antibiotics used w/ in last 2 weeks; number of partners w/ in last month)
- Associated Signs & Symptoms (Ex: discharge, pelvic pain)

<4 = Expanded Problem-focused
>4 = Comprehensive
Review of Systems (ROS):

The ROS is an inventory of body systems obtained through a series of questions asked by the physician seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.
Review of Systems (ROS):

0 organ systems reviewed = **Problem-focused**

1 organ system reviewed = **Expanded Problem-focused**

2-9 organ systems reviewed = **Detailed**

>10 organ systems reviewed = **Comprehensive**

“a comprehensive ROS was negative except for”
Past Medical, Family, Social History (PMFSH)

Past medical history includes the previous illnesses, surgeries, treatments, past medications and allergies.

Family history includes any family history of diseases or illnesses.

Social history includes habits, risk factors, relationship status, occupation and/ or other activities or factors that may impact the patient’s health status.
Past Medical, Family, Social History (PMSFH)

0 elements = Expanded Problem-Focused

1 element = Detailed

2 elements = Established patient comprehensive

3 elements = New patient comprehensive
History must meet or exceed three out of three levels.

Your final level of history is determined by the lowest component level.
### 1997 Exam Content and Documentation Requirements:

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>One to five elements identified by a bullet</td>
</tr>
<tr>
<td>Expanded Problem-focused</td>
<td>At least six elements identified by a bullet</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.</td>
</tr>
</tbody>
</table>
Physical Exam 1995 Guidelines:

**Problem-focused** = A limited exam of affected body area or organ system

**Expanded problem-focused** = A limited exam of affected body area or organ system and other symptomatic or related organ system(s)

**Detailed** = Extended exam of affected body area or organ system and other symptomatic and related organ system(s)

**Comprehensive** = A general multi-system exam of 8 or more organ systems or a complete exam of a single organ system.
Medical Decision-Making

Assessment

Plan

Instruction
Medical Decision-Making Has Three (3) Components

- Number of diagnoses or management options
- Amount and complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

You must meet or exceed the level in 2 out of 3 components
### New Patient Requires 3 out of 3

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical</th>
<th>MDM Complexity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>PF</td>
<td>PF</td>
<td>Straightforward</td>
<td>10</td>
</tr>
<tr>
<td>99202</td>
<td>EPF</td>
<td>EPF</td>
<td>Straightforward</td>
<td>20</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>30</td>
</tr>
<tr>
<td>99204</td>
<td>Comp.</td>
<td>Comp.</td>
<td>Moderate</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>Comp.</td>
<td>Comp.</td>
<td>High</td>
<td>60</td>
</tr>
</tbody>
</table>

**PF** = Problem Focused  
**EPF** = Expanded Problem Focused  
**Comp.** = Comprehensive
Established Patient Requires

2 out of 3

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Physical</th>
<th>MDM Complexity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>PF</td>
<td>PF</td>
<td>Straightforward</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>EPF</td>
<td>EPF</td>
<td>Low</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Comp.</td>
<td>Comp.</td>
<td>High</td>
<td>40</td>
</tr>
</tbody>
</table>

**PF** = PROBLEM FOCUSED

**EPF** = EXPANDED PROBLEM FOCUSED

**COMP** = COMPREHENSIVE
# Time Based Coding

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

| Does documentation reveal total time? | Time:  
|--------------------------------------| Face-to-face in outpatient setting  
|                                      | Unit/floor in inpatient setting    |
| Yes No                               | Yes No                            |
| Does documentation describe the content of counseling or coordinating care? | Yes No |
| Does documentation reveal that more than half of the time was counseling or coordinating care? | Yes No |

If all answers are "yes", select level based on time.
Nurse Visit

99211: Office or other outpatient visit for the evaluation and management of an Established patient, that may or may not require the presence of a physician.

- Requires direct physician supervision
- Modifier 25 not appropriate
- Not paid with drug administration services

Example: Fast-Track/ Express Visit
99211 FACTS

• 99211 office visit does not have any specific key-component documentation requirements.

• 99211 **CANNOT** be reported for services provided to patients who are new to the practice. A new patient is expected to be seen by an MD/ NP level provider.

• 99211 is the only Evaluation and Management (E/ M) code that a Registered Nurse can bill.

• 99211 cannot be used to bill a telephone encounter with a patient. The provider-patient encounter must be face-to-face, thus the telephone encounter does not meet the criteria for billing code 99211.
## Counseling Risk Factor Reduction and Behavioral Change Intervention

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.</td>
<td></td>
</tr>
<tr>
<td>99402</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.</td>
<td></td>
</tr>
<tr>
<td>99403</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.</td>
<td></td>
</tr>
<tr>
<td>99404</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.</td>
<td></td>
</tr>
</tbody>
</table>
Medicare and Medicaid

Use HCPCS Code: G0445 For HI BC to prevent STIs
Submit G0445 claim with ICD-9 diagnosis code V69.8
(other problems related to lifestyle)

MLN Matters® Number: MM7610
# E/M Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25</strong></td>
<td>Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.</td>
</tr>
<tr>
<td><strong>24</strong></td>
<td>Unrelated evaluation and management service by the same physician during a post operative period.</td>
</tr>
<tr>
<td><strong>59</strong></td>
<td>Distinct procedural service</td>
</tr>
<tr>
<td><strong>SE</strong></td>
<td>State or Federally funded programs or services.</td>
</tr>
</tbody>
</table>
Reimbursement for Ancillary Procedures

It is important to capture and bill all services performed during a visit.

Ancillary Procedures:

- **In House labs:**
  - Urinalysis: 81002
  - HCG Pregnancy Test: 81025
  - Wet Prep: 87210

- Venipuncture: 36415

- Lab Handling: 99000

- Injection Administration: 96372

- Medications **J Codes**
  - Ceftriaxone (Rocephin): J0694

- Penis Lesion – Cryosurgery: 54056
# STI & FP Superbill

### NEW PATIENT PROBLEM VISITS (q3 yr. rule)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Problem focused/straightfwd (10 min)</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>Expanded prob. focused/straightfwd (20 min)</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Detailed/low complexity (30 min)</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive moderate complexity (45 min)</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive/high complexity (60 min)</td>
<td></td>
</tr>
</tbody>
</table>

### NEW PATIENT PREVENTIVE MEDICINE (q3 yrs.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99384</td>
<td>Routine physical age 12 - 17 yrs</td>
</tr>
<tr>
<td>99385</td>
<td>Routine physical age 18 - 39 yrs</td>
</tr>
<tr>
<td>99386</td>
<td>Routine physical age 40 - 64 yrs</td>
</tr>
<tr>
<td>99387</td>
<td>Routine physical age 65 and older</td>
</tr>
</tbody>
</table>

### ESTABLISHED PATIENT PROBLEM VISITS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Nurse visit</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>Problem focused/straightfwd (10 min)</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Exp. prob. focused/low (15 min)</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>Detailed/low complexity (25 min)</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive/high complexity (40 min)</td>
<td></td>
</tr>
</tbody>
</table>

### ESTABLISHED PATIENT PREVENTIVE MEDICINE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99394</td>
<td>Routine physical age 12 - 17 yrs</td>
</tr>
<tr>
<td>99395</td>
<td>Routine physical age 18 - 39 yrs</td>
</tr>
<tr>
<td>99396</td>
<td>Routine physical age 40 - 64 yrs</td>
</tr>
<tr>
<td>99397</td>
<td>Routine physical age 65 and older</td>
</tr>
<tr>
<td>COUNSEL SVCS: RISK FACTOR/BH CHG MODIFY</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>□ G0445 Intense STI Prevention semiannual</td>
<td></td>
</tr>
<tr>
<td>□ 99401 Approx. 15 minutes</td>
<td></td>
</tr>
<tr>
<td>□ 99402 Approx. 30 minutes</td>
<td></td>
</tr>
<tr>
<td>□ 99403 Approx. 45 minutes</td>
<td></td>
</tr>
<tr>
<td>□ 99404 Approx. 60 minutes</td>
<td></td>
</tr>
<tr>
<td>SMOKING/TOB CESSATION</td>
<td></td>
</tr>
<tr>
<td>□ 99406 Smoking Cessation &gt;3-10 min</td>
<td></td>
</tr>
<tr>
<td>□ 99407 Smoking Cessation &gt; 10 min</td>
<td></td>
</tr>
<tr>
<td>LAB SERVICES</td>
<td></td>
</tr>
<tr>
<td>□ 81002 Urinalysis (dip w/o microscopy)</td>
<td></td>
</tr>
<tr>
<td>□ 81003 Urinalysis dip/tab reagent w/o micro.</td>
<td></td>
</tr>
<tr>
<td>□ 81025 HCG - Preg. Test</td>
<td></td>
</tr>
<tr>
<td>□ 86317 Hep B surface AB</td>
<td></td>
</tr>
<tr>
<td>□ 86580 PPD skin test</td>
<td></td>
</tr>
<tr>
<td>□ 86592 Syphilis tests; qualitative (e.g.,VDRL, RPR)</td>
<td></td>
</tr>
<tr>
<td>□ 86695 Herpes simplex type 1 AB</td>
<td></td>
</tr>
<tr>
<td>□ 86696 Herpes simplex type 2 AB</td>
<td></td>
</tr>
<tr>
<td>□ 87205 Gram stain smear</td>
<td></td>
</tr>
<tr>
<td>□ 87210 Wet Prep</td>
<td></td>
</tr>
<tr>
<td>□ 87210-QW Wet Prep Medicare</td>
<td></td>
</tr>
<tr>
<td>□ 36415 Phlebotomy for lab specimen</td>
<td></td>
</tr>
<tr>
<td>□ 36414 Capillary stick</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>11981</td>
<td>Insert nonbiodeg drug delivery system</td>
</tr>
<tr>
<td>11982</td>
<td>Removal of nonbiodeg drug delivery system</td>
</tr>
<tr>
<td>11983</td>
<td>Removal &amp; reinsertion of system</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm fitting</td>
</tr>
<tr>
<td>A4266</td>
<td>Diaphragm device</td>
</tr>
<tr>
<td>58300</td>
<td>IUD insertion</td>
</tr>
<tr>
<td>58301</td>
<td>IUD removal</td>
</tr>
<tr>
<td>J7302</td>
<td>Mirena IUD</td>
</tr>
<tr>
<td>J7307</td>
<td>Nexplanon Device</td>
</tr>
<tr>
<td>J7300</td>
<td>Paragard IUD</td>
</tr>
<tr>
<td>J7301</td>
<td>Skyla IUD</td>
</tr>
<tr>
<td>J7306</td>
<td>Implanon IUD</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic injection IM or SC</td>
</tr>
<tr>
<td>J1050</td>
<td>Depo Provera 1 mg X150</td>
</tr>
<tr>
<td>J7303</td>
<td>Nuvaring 1 ring = 1 unit</td>
</tr>
<tr>
<td>J7304</td>
<td>OrthoEvra 1 patch = 1 unit</td>
</tr>
<tr>
<td>A4269</td>
<td>Spermicides (metrogel/sponge)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic injection IM or SC</td>
</tr>
<tr>
<td>J0694</td>
<td>Cefoxitin sodium, 1G IM</td>
</tr>
<tr>
<td>J0696</td>
<td>Ceftriaxone (Rocephin), per 250mg IM</td>
</tr>
<tr>
<td>J2510</td>
<td>Penicillin g procaine, aqueous, up to 600,000 units</td>
</tr>
<tr>
<td>Procedure</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>46916</td>
<td>Anal lesion - cryosurgery destruction</td>
</tr>
<tr>
<td>11200</td>
<td>Skin tags (up to 15)</td>
</tr>
<tr>
<td>17110</td>
<td>LN2 to warts, molluscum (&lt;14 lesions)</td>
</tr>
<tr>
<td>46900</td>
<td>Anal lesion - chemical destruction</td>
</tr>
<tr>
<td>54050</td>
<td>Penis lesion - chemical destruction</td>
</tr>
<tr>
<td>54056</td>
<td>Penis lesion - cryo destruction</td>
</tr>
<tr>
<td>56501</td>
<td>Vulvar lesion - single or simple destruction</td>
</tr>
<tr>
<td>56515</td>
<td>Vulvar lesion - multi or complex destruction</td>
</tr>
<tr>
<td>57061</td>
<td>Vaginal lesion - simple destruction</td>
</tr>
</tbody>
</table>

**Procedure/Female Genital System**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>56605</td>
<td>Vulvar bx - one lesion</td>
</tr>
<tr>
<td>56606</td>
<td>Vulvar bx - each addtl Bx X______</td>
</tr>
<tr>
<td>57420</td>
<td>Colpo entire vagina &amp; cervix</td>
</tr>
<tr>
<td>57421</td>
<td>Colpo entire vagina &amp; cervix w/Bx</td>
</tr>
<tr>
<td>57452</td>
<td>Colpo cervix w/o bx</td>
</tr>
<tr>
<td>57454</td>
<td>Colpo of cervix w/ adj. vag, w/ Bx &amp; ECC</td>
</tr>
<tr>
<td>57455</td>
<td>Colpo of cervix w/ adj. vag w/ Bx only</td>
</tr>
<tr>
<td>57456</td>
<td>Colpo of cervix w/ adj. vag w/ ECC only</td>
</tr>
<tr>
<td>57505</td>
<td>Cervical local exc., Bx or polypectomy</td>
</tr>
<tr>
<td>57511</td>
<td>Cryotherapy cervix</td>
</tr>
<tr>
<td>58100</td>
<td>Endometrial Bx</td>
</tr>
<tr>
<td>58110</td>
<td>EMB additional to Colpo (add on code)</td>
</tr>
<tr>
<td>VACCINES</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>90649 HPV, quadrivalent, dose ___ of 3</td>
<td></td>
</tr>
<tr>
<td>90650 HPV, bivalent, dose _____ of 3</td>
<td></td>
</tr>
<tr>
<td>90746 Hep B, Adult</td>
<td></td>
</tr>
<tr>
<td>90715 Tdap</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VACCINE ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>90471 Admin 1 vaccine</td>
</tr>
<tr>
<td>90472 Admin addtl vaccine</td>
</tr>
</tbody>
</table>
Date: November 1, 2014

CC: STD Screening

Vitals: BP: 120/78; Resp: 18/min  Pulse: 82/bmp

A 24 year old male patient returns to the clinic today for STD screening. Patient denies fatigue, fever, chills, vomiting; No abdominal pain or pain with urination. Sexual Partner – Female; 1 partner in the last 3 month Exposure site(s) – Genital and Oral; Date of last exposure – 1 week ago Condom Use - No Partner has concurrent sex partner; Patient has no symptoms

Medical History: NKDA; No current medications; Patient had gonorrhea 2012; Overall health good Social History: Smoker – 1pk/day; Social drinker – 3 beers/week; No Drug Use
SAMPLE VISIT NOTE (Cont.)

EXAM:
Penis: Within Normal Limits
Scrotum: Within Normal Limits
Testicles: Within Normal Limits
Skin: Within Normal Limits – No rashes or lesions

Assessment: V74.5 STD SCREENING

Plan: Labs Ordered: GC/CT NAATs; Syphilis Testing; HIV testing; Oral gonorrhea NAAT (or oral culture if oral NAAT no currently validated, i.e., MD state lab)

*Patient was counseled 15 minutes face to face on STDs, Condom use and contraception

BILLLED CHARGES: 99212(Level 2 E/M Service), 99401(Counseling), 36415(Venipuncture), 99000(Lab handling)

* 99401 billable charge for a non-Medicaid patient
Documentation of Services

The basic principles for documentation of services provided are:

- If it is not documented, it did not happen.
- If it cannot be understood, it did not happen.
- If it cannot be read, it did not happen.
- If it did not happen, it should not have been paid.
- If it was paid, the money should be paid back.
Diagnosis Codes

ICD-9

ICD-10
ICD-9 Diagnosis

• Providers should select the appropriate ICD-9 codes to describe the patient’s diagnosis, symptoms, complaint, condition or problem indicating why the medical service was performed

• The primary diagnosis - the diagnosis which is most severe or acute - should be listed first, followed by the secondary, tertiary and so on.

• Diagnoses Codes must be complete and specific as possible - taken to the terminal digit
Each medical service, surgical procedure and/or diagnostic procedure should be matched with a corresponding diagnostic code.

When a definitive diagnosis has not been determined, codes reporting the symptom should be used. Do not code “rule-out” statements as the diagnosis.

Conditions that are an integral part of the disease process should not be coded additionally.

Conditions that are not an integral part of the disease process should be coded additionally.
Examples of Status Codes

Status Codes should only be reported as primary in the absence of clinical conditions.

- **V72.31** Routine gynecological examination
- **V70.0** Routine general medical examination
- **V74.5** STD Screening
- **V73.8X** Screening for other specific viral and chlamydial diseases
- **V73.81** Special screening examination, human papillomavirus [HPV]
- **V01.6** Contact with or exposure to venereal diseases
ICD-10

**Deadline:**
OCTOBER 1, 2015
What is ICD-10 and How Will it Help?

• The purpose of ICD-10 is to improve clinical communication and accuracy.

• It will help providers capture more data about signs, symptoms, risk factors and comorbidities to better describe the overall clinical issue.

• ICD-10 will require more precise documentation of clinical care and allow for more accuracy when determining medical necessity.
What is the difference between ICD-10 and ICD-9?

There are a greater number of ICD-10 compared to ICD-9.

Diagnosis codes increase from 14,000 to 68,000 codes

Procedure Codes increase from 4,000 to 87,000 codes

ICD-10 will help providers capture more data about signs, symptoms, risk factors and comorbidities to better describe the overall clinical issue
Revenue Cycle Management
Elements of the Revenue Cycle Management

- Front-end Operations
- Documentation of Services
- Coding
- Charge Capture & Charge Entry
- Claim Submission
- Payment & Denial Management
- Account Receivable Management
- Key Indicator Reporting
- Auditing
Front-end Operations

• Appointment and pre-registration
• Accurate patient and insurance information
• Collect co-pays & balances due
• Verify insurance and benefit information
• Reconciliation processes
## Charge Capture & Reconciliation

- Use visit tracking reports to identify no-shows, missed charges.
- Reconcile posted charges to source documents, e.g., encounter forms (superbills).
- Reconcile encounters to patient sign-in sheets.
- Reconcile service volumes to external resources, e.g., lab logs.
- Reconcile to inventory control for injectables and other billable supplies.
- Post charges within 24 hours of service.
BILLING OFFICE - Claims Submission

Strategies for optimal & accurate claims processing:

- Review & correct claims prior to submission “Clean Claim”
- File claims electronically
- File claims in a timely manner
- Reconcile submission reports to acceptance reports
- Review, correct & refile clearinghouse denials immediately
- Review, correct & refile payer denials immediately
Common Claim Denials

- Demographic errors
- Coding errors
- Billed to the wrong insurance
- Provider is non-par
- No out-of-network-benefits
- Lack of pre-authorization
- Missing NDC number or Units
- Duplicate claim
- Timely filing/appeal
Strategies & Tips to Reduce Payer Denials

- Monitor claim denials to identify trends.
- Use system analyzing reports indicating frequency of “Remark” codes.
- Tracking and categorizing denials by payer and provider.
- Monitor claim denials to identify trends.
- Correct the root denial problems and rejections.
- Follow-up on denials within 24 hours.
- Develop appeal letter templates.
BILLING OFFICE - Payment Posting

Payment Posting:
- Payer Payments
- Patient Payments

Payment Reconciliation:
- PM system report
- EOB’s
- ERA’s
- Bank
Payment Processing Tips

- Enroll in electronic fund transfers (EFT) and electronic remittance advice (ERA).

- Use software to report payment variance from contracted rates to verify that accurate payments are received.

- Reconcile all payments to source documents, e.g., EOBs, super-bills or patient receipts.

- Ensure that the fee structure is above contracted rate.

- Train staff to monitor contractual amounts and bundling edits.
• **Track and monitor key statistics, including:**
  - Charges and payments
  - Days in Accounts Receivable A/R Aging:
    - Current, 31-60 days, 61-90 days, 91-120, Over 120
  - Collection ratios and Aging by payer
  - Denials
  - Patient balances
  - Provide continuing education and ongoing feedback to providers regarding coding accuracy and patterns.
  - Educate staff and reduce errors.
Reports are Essential to A/R Management

• Report Types:
  • Account Receivables Reports
  • Payer Reports
  • Patient Reports
  • Payer Analysis Reports
  • Payer Mix Reports
  • Service Analysis Report
Tools, Tips and Resources
# Sample Work-plan

<table>
<thead>
<tr>
<th>ID</th>
<th>Detailed Activities</th>
<th>Assigned To</th>
<th>Begin</th>
<th>Due</th>
<th>Complete</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Services - Codes - Fees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td>Identify STI and FP services and supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.05</td>
<td>Verify that the appropriate CPT/HCPCS codes for all services/supplies in the PMS and the superbill</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.10</td>
<td>Assign appropriate NDC numbers for all medications administered</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.15</td>
<td>Determine the cost of all medications, vaccines, supplies and tests</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
# Sample Work-plan for Front Office

## SAMPLE STI - Front Office Training & Duties

<table>
<thead>
<tr>
<th>ID</th>
<th>Description of Activities</th>
<th>Assigned To</th>
<th>Begin Date</th>
<th>Complete Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Miscellaneous Duties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td>Appointment scheduling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.05</td>
<td><strong>Pre-registration - collect demographic &amp; ins. info.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td><strong>Pre-authorization of IUD, procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td>This may be assigned to a Clinical person</td>
</tr>
<tr>
<td>1.15</td>
<td>Collects referrals if needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.20</td>
<td>Reminder calls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.25</td>
<td>Answers phones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.30</td>
<td>Gathers and prepares forms in advance of visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Payers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td></td>
<td>Self-Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.10</td>
<td></td>
<td>MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.15</td>
<td>Educate staff how to identify, collect appropriate information and process the different payers</td>
<td>MCO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.20</td>
<td></td>
<td>Payer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.25</td>
<td></td>
<td>Medicare</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Lab Services for Insured clients

LabCorp Payor List
https://www.labcorp.com/wps/wcm/connect/e18311804a162dda9a18ff90b80e7bff/midatlantic.pdf?MOD=AJPERES&CACHEID=e18311804a162dda9a18ff90b80e7bff

Quest Lab Payor List
Attention Patients:

WE CAN NOW BILL YOUR INSURANCE!

No one will be denied services based on ability to pay.

Talk to us about payment options today!
COMING SOON!

We will soon be able to:

.... bill your insurance for services.

.... take care of you even if you don’t have insurance.

.... take care of you even if you cannot pay in full today.

.... continue providing 100% confidential care.
Payment Policy:

Services are not dependent on the ability to pay. Using your insurance or paying for your visit will help ensure that we can continue providing high quality, low cost services to our clients. We accept all forms of health insurance.

If you do not have insurance, or choose not to use your insurance, you will be asked to pay something at the time of your visit. We do not send bills to your home; the clinic visit is the only opportunity for you to pay for your care.

Donations are welcome.

We accept cash, checks, Visa and MasterCard.¹

Dear Patients,

Soon we will be billing health insurance (Medicaid and most Private Insurance) for services. Please be prepared to provide information about insurance status and income. Please bring your insurance card, ID, and proof of income.

Frequently Asked Questions:

What if I don’t have insurance?
If you don’t have insurance you will be charged on a sliding scale fee based on your income and ability to pay.

Will the services still be confidential if you bill my insurance?
We will still keep your services confidential between you and your insurance company, but anyone with access to your insurance plan may know you came today.

What if I don’t want you to use my insurance?
Insurance will be billed only with client’s consent. If you do not have insurance or do not want to use it for your services today because of reasons of confidentiality you will be charged on a “sliding fee scale” based on your current income.

Why are you billing insurance now?
Current and expected cuts to public health funding have made it necessary to look into all the ways we can bring in money to ensure access to services for everyone, regardless of ability to pay. If we are able to bill insurance for some patients it will allow us to keep our services available to everyone.

Will you still see me if I can’t pay today?
We will not turn you away for ability to pay. If you are able, we ask you to contribute a small fee today, or the next time you come in.

Please talk to the registration staff if you have any questions.
Tips for Collecting Payment From Clients

• Create a financial policy
• Place signage in the clinic
• Inform the patient in advance of their financial responsibility
• Communicate the financial policy to the client:
  • When their appointment is made
  • When reminding them of their appointment
  • When the check-in
  • Post the financial policy on the website
• Create a hand-out or brochure
  • List the payers the clinic participates with
Questions and Answers

Additional Questions Please Contact

Elisabeth Liebow, MPH
Policy and Program Associate
Center for Sexually Transmitted Infection Prevention
Infectious Disease Bureau
Maryland Department of Health and Mental Hygiene
500 N. Calvert Street, 5th Floor, Baltimore, MD  21202

410-767-5160 / Fax 410-333-5529
elisabeth.liebow@maryland.gov
Additional Questions Please Contact

**Elisabeth Liebow, MPH**  
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elisabeth.liebow@maryland.gov
Voice 410-897-9888 / www.shrassociatesinc.com / info@shrassociatesinc.com

EHR and PMS system evaluation, implementation assistance and for medical practices, health departments and community-based clinics.

Create, implement and streamline work flow processes for clinics and medical practices

Project Director for the CDC/DHMH Immunization Billing Project for the Maryland Local Health Departments.

Train staff and assist in creating operational and clinical policies and procedures.

Create and present webinars for DHMH, the Texas Sustainability and Capacity Building Network and University of Maryland and private practices and clinics on practice and clinic operations, medical billing, coding, documentation, electronic medical records and practice management systems.

Assist medical practices and clinics transition from paper charts to electronic medical records.

Provide advice, support and training to providers and staff on medical billing issues and third party reimbursement.

SBHC Billing Pilot Program
Ms. Denise Walsh, CPC is Certified Professional Coder and has been working in the healthcare industry for over 20 years. As a Senior Consultant for SHR Associates, Inc. (SHR), Ms. Walsh’s areas of responsibility and expertise include training providers on proper documentation and coding, conducting external chart audits, assisting medical practices and health care organizations in creating and implementing HIPAA and billing compliance plans, designing and implementing revenue cycle management systems that maximize reimbursement, and assessing and restructuring internal practice processes to help streamline and enhance operational efficiency. Ms. Walsh has extensive experience in the credentialing and payer contracting process for new and established providers and has successfully negotiated with insurance plans to obtain increased reimbursement. Prior to joining SHR, Ms. Walsh served in the capacity of Practice Administrator and Billing Manager for several specialty medical practices.

Ms. Walsh received her BS degree in Allied Medicine from The Ohio State University and is a member of the American Academy of Professional Coders (AAPC).