# Shifting to Third-Party Billing Practices for Public Health STD Services: Policy Context and Cases Studies

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National Coalition of STD Directors
*Promoting Sexual Health Through STD Prevention*

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# TABLE OF CONTENTS

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# ACKNOWLEDGEMENTS

The National Coalition of STD Directors (NCSD) seeks to help move the field forward as STD safety net providers develop new business models in response to the shifting funding and policy landscape. This guide is designed to help navigate the many challenges and opportunities that are emerging in public health by sharing the insights and lessons learned on the ground.

The creation of this guide has been a deeply collaborative process relying on the thoughtful contributions and openness of key players from the four sites highlighted in the case studies, an advisory group, and other experts in the field.

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# Introduction

Sexually transmitted diseases (STD) remain a significant epidemic in the United States. Each year, there are approximately 19 million new cases of STDs, about half of which go undiagnosed and untreated. State and local health departments play a critical role in keeping our communities strong and healthy through sexually transmitted disease (STD) and HIV prevention and control services. These activities include clinical services, education and awareness efforts, and surveillance and epidemiology programs that monitor trends in diseases.

Historically these services have been offered for free or at low cost in order to meet the needs of patients—as many as 85 percent of whom live below 150 percent of the federal poverty level. Funding for local and state STD and HIV programs come from a combination of local, state, federal, and commercial dollars. As a result of the economic down turn, however, we have seen a marked decline in discretionary government money at all levels for STD and HIV prevention programs.

Funding for public health services, such as STD and sexual health services, is expected to decrease even further in the coming year, driving the need for providers to supplement discretionary resources. At the same time, under the Patient Protection and Affordable Care Act, Medicaid expansions and access to commercial insurance through state-based exchanges means that many clients who were previously uninsured will be more likely to have health insurance coverage. Despite increasing health care coverage for many individuals who were previously uninsured, a significant population will remain without coverage. Others might be reluctant to seek sensitive services believe these may not be confidential if billed through health insurance. Leveraging the coverage available to the newly insured and ensuring confidentiality will help foster the financial health of STD clinics and programs, ensuring their viability as safety net providers.

Despite this, local and state health departments engaged in direct service delivery must adapt new business models which to respond to the changing landscape. New models include both third-party billing and revenue generation systems. Billing commercial and public third-party payers offers STD programs and clinics additional revenue streams to close budget gaps, striking a healthier balance between mission and margin and supporting long-term sustainability. This revenue can offset the cost of providing free services to patients without health insurance, and free up

resources to fund efforts, such as outreach activities, that are not covered by other funding streams.

Responding to this new reality will require building technical capacity, updating infrastructure to include electronic health records (EHR), and deepening the clinic's integration into the broader health care system. STD clinics will need to ensure that they are a part of Medicaid plans as well as commercial insurance providers' networks and learn how to follow their protocols and requirements.

In light of the dwindling financial resources, health departments must also focus on developing innovative partnerships to ensure the delivery of STD and other sexual health services. Health departments will increasingly assume roles as catalysts, broadening the network of STD related services, and as advisors, building the capacity of a broad array of services providers to deliver HIV testing. In all states, STD and HIV programs are already coordinating with each other as well as with other local and state agencies, such as hospitals, family planning clinics, and Departments of Education and Corrections to promote sexual health in all communities.

The National Coalition of STD Directors (NCSD) is collaborating with key partners to help shift the public health funding and partnerships paradigm for STD clinical services in response to this changing landscape. NCSD is committed to accompanying you as you take the steps to move into this new environment.

NCSD has developed this guide in conjunction with an advisory group of key experts to meet the needs of a range of providers—from those who are unsure that third-party billing is the right fit for STD service delivery, to those who just don't know where to begin or feel overwhelmed at the prospect of jumping in, to those who are ready to begin planning and implementation but don't know what a successful model looks like. This guide does not serve as a technical manual, but rather an introduction to what providers need to consider as they approach the decisions surrounding third-party billing.

This guide includes:

- **Overview** of the policy and funding landscape impacting the decision-making around billing third-party payers, including provisions in the Affordable Care Act that will expand insurance coverage through Medicaid expansion and the development of state-based insurance exchanges.
- **Analysis** of state and local statutory and regulatory obstacles which may impede billing a third party for STD-related services and recommendations for possible solutions.
- Four **case studies** highlighting the experiences of STD programs and clinics that are currently billing third-party payers for STD-related services, or are in the process of laying the groundwork or developing a plan to implement a third-party billing practice. These case studies offer real world examples of partnerships and business models for building relationships with third-party payers.
- Sample **superbill** (encounter form) illustrating a representative selection of International Classification of Diseases (ICD) diagnostic codes and Current Procedural Terminology (CPT) codes used to describe medical procedures to help familiarize you with the way that STD-related services are translated into the language spoken with third-party payers. This section also includes a brief orientation to the forthcoming shift from ICD-9 codes to ICD-10 codes in 2014 in a coding primer.
- Third-party billing **terminology reference sheet** with definition of commonly used terms.
- Throughout the guide we ask **questions** designed to help you draw connection back to your own context and support you as you map out next steps.


# Setting the Stage: Policy and Funding Landscape Impacting Third-Party Billing for STD-Related Services

The imperative for STD programs and clinics operated by state and local health departments to bill third-party payers and generate revenue is unmistakable. Shrinking budgets at state and local health departments mean smaller and fewer public funding streams for STD service delivery, while the passage and implementation of the Patient Protection and Affordable Care Act (ACA) means that more clients will have health insurance coverage through Medicaid expansion and state-based exchanges. In addition, the ACA also means expanded opportunities for insurance coverage of sexual health services and an expanded role in insurance networks for entities that work with medically underserved populations. This means increased opportunities for state and local health departments and adds an extra incentive for STD programs to move toward billing third-party payers.

Billing commercial and public third-party payers for STD-related services can help close budget gaps, offset the cost of providing free services to patients without health insurance, and free up resources to fund efforts not covered by other funding streams, such as outreach activities. It can mean the difference between a clinic closing its doors and gaining long-term sustainability. There are, however, statutory and regulatory obstacles in some jurisdictions which prohibit charging fees for the delivery of STD-related services, regardless of whether the payment is out-of-pocket from the client or from a third-party payer.

In this section we take a look at the current funding landscape, the impact of ACA, and the regulatory challenges to creating a third-party billing system. We also provide sample legislation, regulations, and approaches taken to remedy these restrictions.

## I. FUNDING LANDSCAPE

The recession of 2008 led lawmakers in most states to cut budgets which had a dramatic impact on state and local STD/HIV programs. An NCSD survey of members—STD Directors in state, local, and territorial health departments—found:

- 69 percent of jurisdiction experience that salary freezes and/or reductions
- 50 percent of jurisdictions experienced furloughs and/or shutdown days
- 28 percent of jurisdictions experienced layoffs

In 2009 alone, 69 percent of states cut STD program funding. Given that states are responsible for approximately one-third of their STD program budgets, the impact of these cuts cannot be overstated.[1] Many cuts were made to laboratory, clinical care, and screening services, which translated to fewer

low-income individuals accessing affordable STD and HIV testing and treatment.[2]

In addition to pressures on the state level, the increasing federal debt and deficit has led to pressures to reduce government spending, increasing the likelihood of cuts to federal discretionary programs like STD funding. Since fiscal year 2005, STD funding from the federal government has decreased by almost $6 million. In addition, with ACA creating significant coverage expansions, many in Congress are asking why the federal government should be funding services and activities that Medicaid and the private sector may now be covering through expanded public and private health insurance coverage. With no quick and easy end to this worsening funding outlook, STD programs should be looking to new opportunities to diversify their revenue streams and to ensure necessary activities can still be carried out, even with decreasing investments from government sources.

## II. THE AFFORDABLE CARE ACT: EXPANDING MEDICAID COVERAGE AND ACCESS TO COMMERCIAL HEALTH INSURANCE

Passage of the ACA dramatically increases the role of commercial insurance and Medicaid as sources of coverage for patient care. ACA, signed into law on March 23, 2010, sought to meet the health care needs of the tens of millions of uninsured Americans, and the provisions have a large impact on both commercial and public health care programs.

### The Current Medicaid Program

Currently, to qualify for "traditional" or full-benefit Medicaid, individuals have to meet financial eligibility criteria and belong to one of the following groups:

- Children
- Parents
- Pregnant women
- People with disabilities
- Seniors

Historically, other non-disabled adults have been excluded from Medicaid, regardless of their income, unless a state obtained a waiver to cover them.

Current Medicaid coverage varies widely state-by-state, particularly for adults. Seventeen states currently have eligibility for working parents that is capped at less than 50 percent of the Federal Poverty Level (FPL), and 25 states currently have no coverage for low-income childless adults. The determination of the FPL changes slightly each year and varies depending on the number of people in the household, but in 2012, 50 percent of FPL is an annual income of $5,585 for an individual and $11, 525 for a family of four.

**Key Questions**

1. What are your state's current Medicaid income eligibility levels for different population groups?

### Medicaid Expansion in the Affordable Care Act

Beginning in January 2014, as a result of the Medicaid expansion provision in the ACA states have the option to expand Medicaid to cover *all* individuals up to age 65 with incomes up to 133 percent of the federal poverty level. The federal government will initially pay for 100 percent of the cost of this expansion, with the federal share dropping to 90 percent by 2020 and remaining at that level for all subsequent years.

A total of 22.3 million individuals who are uninsured would be potentially eligible for Medicaid if all states fully implemented this expansion. According to estimates from the 2010 American Community Survey, almost half (47 percent) of the nation's uninsured could qualify for Medicaid under the Affordable Care Act.

**Key Questions**

1. How might the increased number of Medicaid beneficiaries impact your clinic/department?

### Supreme Court's Ruling and its Effect on Medicaid Expansion

Challenges to certain provisions in ACA ultimately led to a review by the Supreme Court in the case of National Federation of Independent Businesses et al. v. Sebelius, Secretary of Health and Human Services, et al. As written, the Affordable Care Act allows states to increase their Medicaid coverage to those with income over 133 percent of the federal poverty level (FPL) and the law gave the Secretary of Health and Human Services the discretion to withhold existing Medicaid funds from states that do not enact an expansion.

The Court upheld the constitutionality of Medicaid expansion, but limited the Secretary's ability to withhold existing Medicaid funds from states that do not comply with the new eligibility requirements. As a result, a state may opt out of expanding its Medicaid program and still keep its existing Medicaid funds. Since the federal government will shoulder most of the financial burden of the expansion, states still have an incentive to expand their coverage but if for whatever reason they choose not to, the federal government has little ability to penalize them.

#### Key Questions

1. How has your governor or state legislature reacted to the Supreme Court's ruling on the Medicaid expansion?

### Impact of states not expanding Medicaid

Which states choose to expand their Medicaid programs and which choose not to has yet to be seen as this provision is not set to be implemented until 2014. But the possibility that any state might not expand its coverage will have a large effect on its poorest citizens. In addition, the possibility that even a handful of states won't expand their programs could have a large effect on coverage in the country as a whole.

ACA also establishes a series of subsidies for lower- and middle-income earners to help them purchase insurance coverage through the exchanges. In any state that does not expand its Medicaid program, some individuals could purchase insurance through the new health insurance exchanges. However, they would likely experience greater cost-sharing for their health insurance coverage than if they were eligible for Medicaid. Furthermore, the subsidies created in the law are only for those with incomes between 100 percent and 400 percent of FPL. As a consequence, uninsured adults living with incomes between 0 and 100 percent of FPL in states that don't expand Medicaid would have access to neither Medicaid nor subsidized Exchange coverage. According to research put out by the Urban Institute in July of 2012, 11.5 million potentially Medicaid-eligible adults fall into the 0 to 100 percent FPL income range.

Click here for more information on how not expanding Medicaid would affect individual states.

Click here to learn more about where your state is in implementing the ACA as a whole.

Click here to learn about your state's progress on expanding the Medicaid program specifically.

#### Key Questions

1. What are your state's plans to expand Medicaid?
2. How far has your state progressed in implementing the Medicaid expansion?

## III. ADDITIONAL IMPACT OF ACA

Expansion of Medicaid coverage is one of the most widely touted benefits of ACA, however there are a range of other provisions which will impact the healthcare landscape. These additional benefits include coverage of key preventive services, requirement for health care plans offered through the state-based exchanges to include essential community providers, as well as expansion of coverage for dependents.

### Coverage of preventive services

The Affordable Care Act requires group and individual private insurance plans to cover certain preventive

health services without any co-pays or costs to the patient (this requirement refers only to plans that are not "grandfathered"). These include all services that receive an "A" or a "B" rating by the U.S. Preventive Services Task Force (USPSTF); all vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP); certain children's services; and women's preventive services identified by HHS. Plans can no longer charge a patient a copayment, coinsurance, or deductible for these services when they are delivered by an in-network provider. Included in these preventive health services that will be covered by health insurance are:

- STD screenings for certain populations
- High intensity behavioral counseling (to prevent STDs)
- HPV vaccinations
- High-risk HPV DNA testing

USPSTF guidelines consider individuals to be high risk if they:

- Have multiple sex partners
- Use barrier protection inconsistently
- Have sex under the influence of alcohol or drugs
- Have sex in exchange for money or drugs
- Are 24 years of age or younger and sexually active (for women for Chlamydia and gonorrhea)
- Have had an STI in the past year
- Use IV drugs (for hepatitis B only)
- Are in a community with a high prevalence of Chlamydia, gonorrhea, and syphilis (for women)
- Are men having sex with men and engaged in high-risk sexual behavior, at any age.

Insurance companies must also cover, with no co-pays, High Intensity Behavioral Counseling (HIBC) to prevent STDs for all sexually active adolescents, all sexually active women, and those men at increased risk for STDs. HIBC is a "program intended to promote sexual risk reduction or risk avoidance" that includes "education, skills training and guidance on how to change sexual behavior."

Many patients at STDs clinics may now have insurance coverage for services traditionally provided by state and local STD departments.

### Key Questions

1. To which patient populations that you see will this expansion of coverage of preventive services apply?

### Essential Community Providers

As noted above, the ACA calls for states to establish new marketplaces, called health insurance exchanges, for small businesses and individuals who do not have access to affordable insurance coverage through their employers. Individuals with incomes between 100 percent and 400 percent of FPL will be eligible for subsidies to help purchase insurance in the exchanges.

The ACA also includes a requirement that certified plans in the exchange include in their networks, as available, "essential community providers [ECPs]",

Outlined below are the USPSTF grade A and B recommendations for STDs:

| | Nonpregnant women | | Pregnant women | | Men | |
|---|---|---|---|---|---|---|
| STI | Not at increased risk | At increased risk* | Not at increased risk | At increased risk* | Not at increased risk | At increased risk* |
| Chlamydia | | A | | B | | |
| Gonorrhea | | B | | B | | |
| Syphilis | | A | A | A | | A |
| HIV | | A | A | A | | A |

that "serve predominantly low income, medically underserved individuals." By statute and regulation, all entities that currently participate in the 340b drug pricing program and those providers that are eligible for the 340b program based on receiving funding under section 318 of the Public Health Service Act are defined as "essential community providers." The base grant received by STD programs, Comprehensive STD Prevention Systems (CSPS), is part of Section 318 funding, so any STD clinic run by an entity that receives funding under CSPS can be deemed a 340b provider through state health department certification and therefore be considered an "essential community provider."

The law does not require the insurance plans to have STD clinics in their network, but plans will need to demonstrate that their networks include adequate access to ECPs. As a result, being deemed an ECP could make an STD clinic more attractive to an insurance plan and increase the likelihood for inclusion as an in-network provider. STD clinics should confirm with their state department of health that they have been registered as ECP. In addition, they should track their state's creation of a state-based exchange and learn how the state is requiring plans to contract with ECPs. Keep in mind that some states' exchanges are being setup by the federal government ("federally facilitated exchanges") or may be hybrids in which the state performs some functions and the federal government performs others.

### Key Questions

1. According to your state Department of Health, does your clinic qualify as an ECP?
2. Who or what entity is responsible for setting up your state's exchange?
3. How can you make a business case for yourself as a partner with the insurance companies participating in that exchange?

## Expansion of Dependent Coverage

Young people bear a disproportionate burden of STDs. Those ages 15–25 make up half of the population contracting STDs annually, but only one-fourth of the sexually active population. In addition to being at increased risk for STDs, young adults are more likely to be uninsured than those in any other age group.

Under the ACA, insurance plans are required to allow parents to extend coverage to all children -under the age of 26, regardless of whether they are currently students, married, or listed as dependents on their parent's tax returns.

This expansion of coverage currently applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her own job). Beginning in 2014, however, children under age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

This expansion of coverage for a high-risk population is beneficial but when it comes to STD screening and testing, issues of confidentiality still exist.

### Key Questions

1. How might the ACA's expansion of coverage for young adults affect the clients and patients you and your partners see?

## Continued Importance of Safety Net Services

The ACA marks a major transition in the United States with significant expansion of health insurance and increased health care access for millions of Americans. Despite the promise of the law, however, the need for safety net services, like those provided by STD clinics and partners, is still great.

Despite the availability of health exchanges, some individuals may choose not to participant. Starting in 2014, however, there will be a penalty for individuals who do not have health care coverage. The penalty starts out fairly low in 2014 at $95 for an individual, or one percent of a person's income, whichever is greater. In 2016, when the penalty is fully phased in, it will be $695 for an individual (up to $2,085 per family) or 2.5 percent of household income, whichever is greater.

The penalty will increase annually based on the cost of living. It is important to note, however, that the U.S. Department of Health and Human Services has stated that people living in states where they would have been eligible for expanded Medicaid coverage will not be penalized for their state's failure to expand the program. Individuals are exempt from the requirement to purchase health insurance coverage if their income level does not reach the minimum amount required to file income taxes or if the cost of health insurance premiums after employer contributions and federal subsidies exceeds eight percent of their income.

The ACA will expand both commercial insurance and Medicaid coverage to millions of Americans but even with full implementation of the law in 2014, there will still be millions of people who do not have health insurance coverage. For example, as noted above, the Supreme Court's ruling on the Medicaid expansion could leave up to 11.5 million Americans without coverage, should states choose not to expand their Medicaid programs. In addition, there will still be those who do not choose to purchase insurance for religious or other reasons. And there will be those who are undocumented (or have fears of being deported despite their legal status) who will not have access to health insurance coverage.

Moreover, having health insurance coverage does not equal having access to health care services or guarantee high-quality care. Some individuals may still have difficulty finding a good health care provider who takes their insurance coverage. In truth, it is unlikely that the current number of private health care providers will be able to absorb the number of new patients to whom the ACA will expand insurance coverage. In addition, health insurance alone cannot address the types of health care access barriers that keep certain individuals from accessing health services that community providers (like STD clinics) often provide, including patient support services, language services, specially trained providers, strategic locations, and integration with health and social services. Safety-net providers will still be needed and should increase their ability to bill third-party payers in order to be able to provide services to the newly insured.

The Affordable Care Act is a historic step forward for health coverage in this country and will dramatically change how health care services are paid for. As sexual health providers, you will be faced with a more varied funding base and should now be moving to a billing structure. That said there will be those who fall through the cracks of coverage and we need to ensure that safety-net services like yours continue to exist because when it comes to STDs, lack of access to screening and treatment can threaten the health of the entire community.

**Key Questions**

1. What will your role, as a safety net provider, be after the full implementation of ACA in 2014?

## IV. STATUTORY AND REGULATORY ISSUES RELATING TO THIRD-PARTY BILLING IN STD SERVICE DELIVERY SETTING

As STD programs and clinics affiliated with state and local health departments begin building the infrastructure necessary to bill third-party payers, you must evaluate state and/or local laws and regulations to ensure there are no legal or regulatory obstacles. For example, New York, Pennsylvania, and West Virginia, among others, require that all STD-related services provided by state and local health department entities be delivered free of charge. Title I § 2304.[1] of New York code, for instance, states:

> It shall be the responsibility of each board of health of a health district to provide adequate facilities for the free diagnosis and treatment of persons living within its jurisdiction who are suspected of being infected or are infected with a sexually transmittable disease.[3]

Depending on the exact wording and legislative intent, these regulatory and statutory obstacles may prevent some providers from billing third-party payers for STD-related services. A detailed look at state and local codes may uncover a way to work around these rules. In other places it may be necessary for advocates to work to change the law.

## The History of Statutory Prohibitions against Fee-for-Service STD Care

Statutes and regulations prohibiting charging a fee for service offered by STD programs and clinics affiliated with state and local health departments are not uncommon in the United States and date back to the 1940s and 50s. For example, Pennsylvania's law requiring free STD services was enacted in 1956. The laws emerged in response to a serious syphilis epidemic that swept the U.S. in the years leading up to and after World War II. Men returning from service abroad functioned as a bridge population between Southeast Asia/Europe and the U.S. and often brought home STDs.[4]

In many ways, the medical ethos of the U.S. in the 1940s and 50s was not substantially different than it is today. Talking about sexual health was taboo and young men rarely discussed it with their physicians, making diagnosis and treatment difficult. Moreover the lack of medical privacy left many men feeling that they had few places to turn for confidential testing and treatment. It was not uncommon for physicians to disclose their patient's sexual histories to his/her spouse. These obstacles made combating the syphilis epidemic almost impossible.[4,5]

In response, members of the U.S. Public Health Service Corps advocated for state laws ensuring that states assumed responsibility for addressing the epidemic. Laws, like those in New York and Pennsylvania, ensured that residents always had a place to obtain STD-related services from medical professionals.[5] Creation of these laws, and subsequently STD-specific clinics, enabled individuals to obtain treatment from practitioners other than their own family physicians, alleviating some privacy concerns. A significant number of these laws also sought to eliminate economic barriers to diagnosis and treatment, articulating prohibitions to charging fees for services. Implementation of these laws were supported by large public health funds sent to states from New Deal-era programs.[4] These clinics and widespread use of antibiotics nearly eliminated syphilis in the US.[4,5] While these laws were created in good faith, and some level of free service delivery may always be necessary as a public health, they may unintentionally block third-part billing systems.

### Key Questions

1. Does your state have a law that might prohibit third party billing? (If you are unsure examine your laws related to infectious disease or public health as any fee-for-service prohibition will likely be there.)

## Legal Interpretation May Provide a Solution to Statutory and Regulatory Obstacles.

These laws are interpreted in two ways. First, they can be viewed as an absolute prohibition against STD clinics billing a patient's public or commercial health insurance for STD-related services. Under such an interpretation, a state or local health department-affiliated STD clinic that attempts to bill a third-party payer is considered to be charging a fee for service, which violates the basic tenant of such laws even if the patient does not incur any direct cost. Requiring any copayments would also be considered contrary to these laws.[5]

However, these have also been interpreted in such a way as to allow STD programs to bill third-party payers if there is no fee to the patient. In Pennsylvania, for example, the Department of Health's in-house legal counsel issued an opinion stating that billing third-party payers for STD- related services does not violate the Department's requirement to provide free services.[5] Pennsylvania's statute states:

> (a) The Department will provide or designate adequate facilities for the free diagnosis and, where

> necessary for the preservation of public health, free treatment of persons infected with sexually transmitted diseases. (b) Upon approval of the Department, a local health authority shall undertake to share the expense of furnishing free diagnosis and free treatment of a sexually transmitted disease, or shall furnish free diagnosis and free treatment of the sexually transmitted disease without financial assistance from the Department.[6]

The Department's counsel reasoned that because neither a fee nor insurance was a requisite of service, the Department could ask patients to voluntarily use their health insurance. As long as no patient was charged, then the provisions for "free care" in Chapter 27 did not preclude the STD Program from seeking reimbursement from third-party payers.[5,6] Obtaining a similar opinion from either in-house legal counsel or the Attorney General's office is the easiest and fastest way to remedy these prohibitions. STD program managers in states with similar laws on the books may wish to first seek a legal opinion before considering a change to statute.

### Key Questions

1. If your state has a law like this on the books, how does your health department's legal counsel interpret this law?
2. If your state has a law like this on the books, how does your state's Attorney General interpret the law?

## Statute Change May Provide a Solution to Statutory and Regulatory Obstacles

A stringent interpretation of these laws is not uncommon, and some STD program managers may find themselves held to the letter of the law. A number of STD program managers in states where strict interpretations have been handed down by in-house counsel or the Attorney General's Office are working with coalition partners to revisit the statutes. New York's tuberculosis (TB) code may serve as good model language for those seeking to remedy a constraining law. TB laws in many states, including New York, were designed to ensure free services to ill patients —as a matter of treating them and of protecting the general public's health.[7] New York's TB code gives patients the option of paying and/or using their insurance so long as the ability to pay is not a requisite for care and treatment. Title I § 2202.1e-2 states:

> 1. (e) Diagnoses, tests, studies or analyses for the discovery of tuberculosis and care and treatment by a hospital, as defined in article twenty-eight of this chapter, or by a certified home health agency which are provided by the state or by any county or city shall be available without cost or charge to the persons receiving such examinations, care or treatment, except that the third party coverage or indemnification shall first be applied against the total cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment of the individual's care and treatment as hereinafter provided.
>
> 2. Any person who volunteers to assume and pay for the cost of such hospital care and treatment or for the cost of such diagnosis, test, study or analysis shall be permitted to do so; but no state, county, city or other public official shall request or require payment or make, or cause to be made, any inquiry or investigation for the purpose of determining the ability of a person or of his legally responsible relatives to pay for diagnoses, tests, studies or analyses for the discovery of tuberculosis or for care and treatment provided by a hospital, as defined by article twenty-eight of this chapter, or by a certified home health agency except to determine if there is third party coverage or indemnification to pay or indemnify all or part of such cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment.[8]

This language is easily adapted to amend state STD laws in such a way that allows billing third-party payers.

### Key Questions

1. Is a statute change the appropriate course of action for you? (If so, connect with your legal counsel about modifying the relevant state codes.)

## Statutes to Help Ensure Patient Confidentiality

Ensuring patient confidentiality in a third-party billing setting is a complex and important issue. The process of third-party billing can result in inadvertent confidentiality breaches, typically in the form of statements that are sent to policy holders. These forms can include explanation of benefits (EOB), denial of claims, acknowledgement of claims, requests for additional information, and payment of claims. These forms may be especially troublesome for young people on their parent's insurance policy as well as domestic partners whose insurance comes through a spouse.[9] Adolescents may risk disclosure of STD-related care to a parent or guardian and adults may risk disclosure of their sexual history to a partner or spouse. These breaches can result in a family member preventing the patient from obtaining further care or worse in the abuse of a patient.[10]

States like Delaware have attempted to remedy this situation by adding language on confidentiality for STD-related services to their public health code which forbids sending any bill, EOB, or other identifying information to minor patients or the policy holders of their insurance policies.[11] While this is specific to minors' STD services, it can be modified to serve as model language for states attempting to create a similar exception for STD patients of all ages. Title 13 § 710 states:

> Any health facility or health care professional may examine and provide treatment for an STD for any minor if such facility or professional is qualified to provide such examination or treatment. Consent to examination and treatment by a minor shall be controlled by § 707 and 708 of Title 13. The health care professional in charge or other appropriate authority of the health facility or the health care professional concerned shall prescribe an appropriate course of treatment for such minor. The fact of consultation, examination and treatment of such minor shall be strictly confidential and shall not be divulged by the facility or the health care professional, including sending of a bill for such services to any persons other than the minor, except as follows:
>
> (1) To persons providing consent pursuant to § 707 of Title 13 or persons informed of the minor's testing and treatment under § 708 of Title 13;
>
> (2) As is necessary to comply with the requirements of Chapter 9 of this title relating to child abuse investigations; or
>
> (3) As is necessary to comply with the requirements of this chapter concerning the control and treatment of STDs, as well as the permitted dissemination of records and information under § 711 of this title."[11]

A recent report by the Guttmacher Institute, "Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies," highlights several other states that have enacted similar legislation. New York and Wisconsin, for example, do not require that an EOB be generated if no balance is due. The same states have also specified that if an EOB is generated, it must be sent using whatever address or means of communication that the patient requests. Similarly, Hawaii currently requires that health care providers ask insurers to halt all communications about sensitive services if the patient makes such a request.[9] Codifying exceptions like these may prove difficult in politically conservative climates. However, there are options that do not require statute change. Those options may include developing agreements with insurance providers, whereby they agree not to generate EOBs for STD-related services. Health departments may also utilize billing codes that do not directly identify the services rendered.[10]

### Key Questions

1. What patient confidentiality protections, if any, already exist in your state? Again, your legal counsel can help you make a thorough review of these laws, and NCSD is also available to help.
2. If a statute change is in order, NCSD is available to assist in preparing an appropriate policy maker education strategy.

## Ensuring Third-party Revenue Returns to Program

Finally, STD programs may want to ensure that revenue generated from third-party billing is returned to the STD program. Several strategies may prove helpful depending on the funding relationship of the STD program to state or local authorities. STD programs housed in locally controlled regional, county or city health departments seem to be well positioned to ensure that money generated from third-party payers is returned to the STD program. These health departments are typically able to track sources of revenue by program.

Tracking revenue in this manner does not necessarily ensure that those dollars are returned to program. Typically, a health department's revenue is placed in its general fund and appropriated according to various priorities. However, STD personnel can use revenue tracking data to suggest to budget writers that revenue generated by STD programs should return to program. Some health departments use these arguments to good effect, resulting in robust funding.[12] STD program managers may also look to their counterparts in immunization programs for experience in ensuring revenue from third-party payers return to the program. Many state and local immunizations programs are currently billing third-party payers. Immunization program managers in these jurisdictions are developing close relationships with budget writers and making "handshake" agreements which guarantee third-party payer revenue returns to the program.[13]

STD programs and clinics that are directly funded and controlled by the state may find it difficult to ensure that third-party payer revenue returns to the program. Revenue generated by billing third-party payers in STD programs and clinics that are controlled by state departments of health is typically first returned to the state general fund. STD program managers in these circumstances will need to work closely with their Health Directors to encourage lawmakers to return third-party payer revenue to the program.

### Key Questions

1. If you have a third-party billing practice in place, trace what is the course the reimbursements take before arriving at your program's account?
2. Who is responsible for appropriating your department's and program's funds? Once you connect with them, what strategy for would ensure that billing revenue is returned to your program?

## POLICY AND FUNDING WRAP-UP

Implementation of the ACA will enable millions of additional Americans to access public and commercial health insurance yet because of the level of sexual health expertise and confidentiality public health departments provide, many of the newly insured will continue to use these for STD testing and treatment. Given the recent cuts to these programs, many individuals will need to be encouraged to use their insurance to obtain needed care. Reimbursement from third-party payers offers STD programs and clinics additional revenue streams to close budget gaps, striking a healthier balance between mission and margin.

STD program administrators must work closely with lawmakers to educate them about the current policy obstacles that prevent their programs from both serving patients and maintaining financial health. NCSD maintains a robust state policy program and is happy to assist you in the process of educating your state lawmakers about the obstacles to billing third-party payers. Feel free to contact the NCSD at StatePolicy@ncsddc.org.

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# Introduction to Case Studies

The National Coalition of STD Directors (NCSD) developed four case studies highlighting the experiences of STD programs and clinics that are currently billing third-party payers for STD-related services, or are in the process of developing a plan and laying the groundwork to implement a third-party billing practice. These cases studies offer real world examples of partnerships and business models for building relationships with third-party payers.

Below is a list of the sites explored in each case study along with a snapshot of what is unique about each site.

### DENVER METRO HEALTH CLINIC
Denver, CO

- Emerging model of third-party billing practice
- Integrated sexual health services (FP/STD/HIV)

### MULTNOMAH COUNTY STD CLINIC
Portland, OR

- Categorical STD Clinic
- Third-party billing practice in a clinical setting
- Collaboration with billing office serving the entire Health Department

### RED DOOR SERVICES
Minneapolis, MN

- Overall public health setting, co-housed with other clinics
- Long-standing and well-honed system support

### PHILADELPHIA HIGH-SCHOOL STD SCREENING PROGRAM
Philadelphia, PA

- Third-party billing for school-based screening program
- Collaboration between the Philadelphia STD Control Program and the Family Planning Council


# Case Study: Denver Metro Health Clinic

The Denver Metro Health Clinic is a full-service STD/FP clinic that also offers confidential testing and treatment for a range of sexually transmitted diseases including HIV, gonorrhea, Chlamydia, syphilis, genital warts, non-gonococcal urethritis (NGU), pelvic inflammatory disease, and various vaginal infections, as well as a range of family planning services. The Denver Metro Health Clinic is part of Denver Health, the primary safety net institution in the city, which "integrates acute hospital and emergency care with public and community health to deliver preventive, primary and acute care services."

Denver Metro Health Clinic is currently undergoing a strategic planning process to support the implementation of a third-party billing practice.

## I. OVERVIEW

### Profile of Clients Served

The Denver Metro Health Clinic is the largest STD clinic in the Rocky Mountain region, serving residents of Denver County and the surrounding area. In 2011, the clinic had 15,000 visits (including follow-up visits) from approximately 10,500 unique clients for STD-related services. In addition, there were 8,100 family-planning related visits, and 9,200 individuals were tested for HIV (6,800 of whom were tested on-site).

| | | |
|---|---|---|
| AGE | 15-24 year olds | 30-40% |
| | 25-39 | 40% |
| | 40-49 | 10% |
| | 50+ | 10% |
| ETHNICITY/RACE | Latino/Latina | 30% |
| | Caucasian | 31% |
| | African-American | 14% |
| | American Indian | .5% |

Men who have sex with men make up approximately 14 percent of the client population.

### STD Profile

At the end of this section there is a chart explaining the STD profile of the local population.

## II. FINANCIALS

### Budget

Denver Metro Health Clinic had an annual budget of $2.7 million in 2011. The clinic received $1,229,097 from the City and County of Denver, $211,890 from three surrounding counties, $1,029,540 in Title X Family Planning dollars, and $316,489 from various grants.

### Payment Options

Denver Metro Health Clinic currently offers services free of charge to those living in a four county area that

includes Denver County, as well as Arapahoe, Adams, and Douglas Counties. Clients living outside of this four county area are charged $65 if they are symptomatic and $30 if asymptomatic. Clients referred by the Vice Squad are charged $65 for services.

Denver Metro Health Clinic calculated that the actual cost of service for an average comprehensive STD/family planning visit in the clinic is approximately $175, with rough estimates of expenditures as follows:

- $100 Personnel and medical supplies
- $35 Laboratory services
- $40 Facility services including pharmacy (but not including the actual cost of medications)

Denver Metro Health Clinic is in the process of determining the payment options that will be available to clients once a third-party billing practice has been implemented. It is developing a triage protocol to assess a client's insurance coverage and whether he/she is high priority/high risk. If a client has insurance, he or she will be scheduled for an appointment. If the client does not have insurance, a Registered Nurse will determine if he/she is a priority patient. Priority clients include those who are symptomatic, had contact with someone who has an STD, received a positive test result which requires treatment, had a local or state health department referral, had been sexually assaulted, or requires post-exposure prophylaxis. These high priority clients will be seen, regardless of insurance coverage and ability to pay.

At the time of publication, Denver Metro Health Clinic was considering a prorated fee of $100 for a comprehensive visit; $45 for a follow-up visit, a visit that just includes tests (no consultation with a provider), or a visit for genital wart treatment; and no fee for clients 18 years of age and younger. These fees would be adjusted on a sliding scale based on reported income.

Patients without a current payer source will be given information on insurance options and encouraged to enroll in a private or public payer program, most commonly Medicaid.

### Key Questions

1. What are the payment options available in your clinic?
2. What does your budget look like? What is the funding forecast? What would be the desired impact on your budget from billing third-party payers?

## III. WHY BILL?

### Rationale for Third-Party Billing

The decision to bill third-party payers did not come easily to the Denver Metro Health Clinic. Title X funds for family planning services have been decreasing as have city and county funds, which each saw up to 10 percent cuts over the last several years. The clinic saw the anticipated changes in the health care system as an opportunity to plan for a future in which more of their patients are likely to have health insurance. As part of a larger hospital and Federally Qualified Health Center system, the clinic had internal resources to draw upon in order to implement billing.

Thus, the decision to develop a third party billing practice was based on the clinic's strength, the opportunity provide by expanding health coverage, and the reality of the funding situation now and moving forward.

### Key Questions

1. What are three critical reasons for your clinic to bill third-party payers for STD-related services?
2. Who would be a likely champion in your city or county? How might you cultivate his or her support? Who would be a likely to present roadblock and how might you address this challenge?
3. What infrastructure, resources, or other support might be available to you through partnerships?

## IV. HISTORY OF BILLING

The Denver Metro Health Clinic has looked at questions relating to revenue generation off and on over the last decade. Ten years ago it implemented a fee-for-service program, but saw an approximately 20 percent drop in Chlamydia and gonorrhea testing in at-risk adolescent populations. The clinic decided to switch back to fee-free services.

The conversation turned back to third-party billing about four years ago. The staff found that the planning process was not as daunting as they had anticipated. They remarked that one of the keys to their success was breaking down the larger goals into a series of smaller, more manageable steps.

First, they developed a funding proposal and received a grant from the state health department's family planning program to support a strategic planning and development process for a third-party billing practice. While the clinic initially worked with a consultant, once they started to explore the feasibility and map out a plan of action, they began to realize that they had many of the resources and expertise internally.

In assessing the feasibility of billing third-party payers for STD related services performed at the Denver Metro Health Clinic, staff evaluated coverage of the population served. For two months in the fall of 2011, intake staff gathering the regular demographic information also collected information about health insurance coverage. They learned that:

- 7.11 percent of those seeking services had Medicaid coverage
- 14.97 percent of those seeking services had commercial insurance coverage
- 5.75 percent of these seeking services were eligible for discounted services through the Colorado Indigent Care Program (CICP)

They also estimated, based on the income of those seeking services, approximately 65 percent of them would be eligible for Medicaid in 2014 under the expansion provision put into place by the Affordable Care Act.

Key staff and leadership of the Denver Metro Health Clinic then met weekly for approximately eight months. In order to assess the financial feasibility, they took several steps to:

1. Determine the level of service provided to understand how each client visit would be coded, and thus the likely charge.
2. Determine the cost of service delivery using a costing analysis model
3. Project the potential revenue based on the payer mix of the population served.

Then, in late April 2012, they undertook an intensive strategic planning process to "develop, test, train and document a process to bill insured and non-insured patients in order to increase the patient population [they] serve and operating revenue." The strategic planning process took place over four days, in a series of eight-hour meetings.

The principle goals of the strategic planning process focused on enabling the clinic to develop systems, protocols, and resources that would support a practice of billing third-party payers for services. They also sought to create new clinic flow protocols that would enable the clinic to increase the number of patients served while also decreasing patient wait time. Noting that they would need additional skills in order to develop and carry out these goals, they also indicated a need to build capacity. During this planning process, the participants also identified their concerns about potentially negative outcomes, such as an increased workload for staff and a decrease in clients willing to come to the clinic. They also expressed uncertainty about whether or not there was sufficient health insurance coverage among the population served by the clinic to warrant a third-party billing practice. Through this process, they developed a work plan to build a third-party billing system, mapping out key milestones, and goals.

In order to understand the insurance coverage of the population being served, they sought to identify any challenges clients might have in enrolling in Medicaid. The participants also considered staffing needs to manage and input data, mapping out an optimal clinic flow.

Despite initial concerns about challenges which would impede a third-party billing practice, particularly around lack of resources and expertise in this area, simply starting on the planning process and breaking down the steps needed, Denver Metro Health discovered that this was not as daunting an unattainable as once perceived.

After much careful consideration and thoughtful planning, on August 15, 2012, the Denver Metro Health Clinic implemented the processes to bill third-party payers.

### Key Questions

1. Have you considered billing third-party payers in the past? What advantages and disadvantages were identified?
2. Who would you assemble into a planning team? What resources or expertise do you have internally that might fuel such a planning process?
3. Of the population you serve, what percentage has Medicaid or is likely to have Medicaid as ACA moves forward? What percentage has commercial insurance? What percentage is uninsured and is likely to remain uninsured as ACA moves forward?

## V. BILLING PROCESS-RELATIONSHIP WITH THIRD-PARTY PAYERS

While it isn't necessary to have a direct relationship with all third-party payers in a given geographic location, in order to maximize the success of any claims submitted, it is critical for the clinic to establish a relationship with the third-party payers most frequently held by clients. Executing a contract with a third-party payer is a requirement of becoming part of the payer's network. Third-party payers negotiate the rates they will pay for services, and frequently cover a higher percentage of the overall cost, for in-network providers.

As part of the larger Denver Health system, the Denver Metro Health Clinic is able to tap into the existing relationships with third-party payers. In this case, the process for establishing contracts is not determined at the clinic level, but rather across the entire health care system. The finance department spearheads the contracting process.

All health care providers are credentialed with third-party payers when they are hired. This means that Denver Health provides the third-party payer with the necessary documentation to demonstrate the qualifications of the health care provider, including, but not limited to state medical license(s), tax documentation, provider ID numbers for Medicaid, and information about education and training.

### Key Questions

1. If you are part of a larger agency, is there another clinic or department that already has a relationship with a third-party payer?
2. What would be helpful to learn from them?

## VI. BILLING PROCESS-PATIENT FLOW

Denver Metro Health Clinic developed several new materials to support the implementation of its third-party billing practice. One of the critical new resources is a revised client registration form that is intended to capture critical information about insurance coverage. The form asks clients if they have health insurance. Clients who have health insurance are asked for the name of their provider, Group number, and ID number. Clients who do not have health insurance are asked if

they would be able to pay out of pocket for the services rendered. Clients are given the fee schedule mentioned earlier under which the clinic charges $100 for a new visit and $45 for a follow-up visit, a "test-only" visit, or genital wart treatment. Clients are also told that the fees are sliding based on income.

As mentioned earlier, the fee system is also based on how urgently patients need to be seen. Denver Metro Health Clinic estimates that approximately 30 percent of the patients seen are asymptomatic, indicating lower risk, and lower urgency in being seen by a provider. The clinic is still figuring out how to best triage those asymptomatic patients who have no insurance coverage and no ability to pay. While the goal is not to reduce the number of asymptomatic patients seen, staff is looking for alternative sites or methods by which they might screen these clients in a more cost-effective manner.

### Key Questions

1. How many clients do you see with symptoms? How many clients are asymptomatic but in a high-risk group? How many are asymptomatic, but are seeking testing? How might the ability to pay impact service delivery to any of the above clients?

## VII. BILLING PROCESS-CLAIMS PROCESSING

After thorough and thoughtful planning, the Denver Metro Health Clinic began billing third-party payers on August 15, 2012. The clinic is able to leverage the resources within the larger Denver Health system to support its billing practice. Once the client's data has been entered into the electronic health records system by the clinic staff, the billing department is responsible for generating the claim and submitting it to the third-party payer. The finance department is then responsible for following up on any delayed or denied claims.

Due to the large volume of claims generated by Denver Health overall, Denver Metro Health Clinic receives an intermittently adjusted percentage of the claims generated by the clinic rather than receiving direct remittances for each individual claim. The percentages are based upon historical reimbursement percentages across the agency for the respective third-party payer relative to the standard charges. The finance department then internally credits the clinic's account for this amount.

## VIII. PARTNERSHIPS, COLLABORATION, LEVERAGING RESOURCES

One partnership and resource that was particularly critical to the success of launching this effort was the grant from the state health department that Denver Metro Health obtained to undertake the strategic planning process. This enabled the clinic to dedicate financial resources with the specific intention of conceptualizing and mobilizing a thoughtful and strategic approach.

### Being Part of the Denver Health and Hospital

Authority, has also brought many advantages. Denver Metro Health Clinic has been able to call on some of the resources within the broader system to support the development of its third-party billing efforts. For example, the staff has worked with specialists from the coding and billing departments to create a superbill. This superbill lists all of the sexual health related diagnostic codes (ICD-9) and procedural codes (CPT) that are likely to be used by the providers in the clinic. The content of this superbill will then be added to a charge master for the entire hospital system.

**Key Questions**

1. What steps might you take to cultivate a partnership to support the development and/or implementation of your own third-party billing practice? Who will you seek advice from on billing, coding, and documentation in medical records?
2. If you work in the Health Department, but are not directly connected with the STD clinic or outreach program, how might you be able to offer support in implementing a third-party billing practice?

## IX. STAFF AND PROVIDERS

The Denver Metro Health Clinic has the following staff and providers:

- Two clerical staff
- Three medical assistants
- One Licensed Practical Nurse
- Five FTE Registered Nurses
- Two Nurse Practitioners

As Denver Metro Health Clinic staff and leadership were considering the benefits and disadvantages of moving forward with third-party billing, one consideration consistently emerged: Staff resistance. Clinic staff was somewhat resistant to change because it required adapting and adopting new systems, protocols, forms, and patient flow, but also out of concerns that third-party billing might interfere with the delivery of services and fulfillment of their public health mission.

In order to bring staff on board, the leadership team created a collaborative and consultative process that allowed staff input in the planning process and worked to foster an environment in which open dialogues about concerns were welcome. The staff was advised early on in the process that change was coming to the clinic, and that they could actively contribute to that process. As a result many ideas have emerged from staff persons that were not part of the original vision; these ideas helped to strengthen the approaches. Moreover, the leadership team continued to explain, "this is an extraordinary opportunity to support and expand our mission" and encouraged staff to get comfortable with not having every detail in place and not always knowing what the right answer will be.

**Key Questions**

1. What might be some areas of resistance from staff or providers at your clinic?
2. What approaches have been helpful in resolving past conflicts of opinion? Would it apply in this context as well?

## X. MESSAGING TO CLIENTS

Communication with clients can play a critical role in ensuring that they understand the third-party billing practice. Denver Metro Health has factored the needs of their clients throughout their planning process. They are currently finalizing their communication plan which will include:

- Handouts
- Information on the clinic website
- And scripts/talking points to guide staff conversations with clients on the phone or in the clinic.

## XI. CAPACITY BUILDING

Administrators at the Denver Metro Health Clinic also spent significant time understanding the business operations related to coding and billing. They learned how to access the computer programs necessary to fully register patients and capture payer information. In addition, they developed a superbill that collates the most common charges and diagnostic codes that they would utilize in the clinic.

Once this was in place, clerical staff received training to operate the computer programs needed to record

and verify financial information, as well as record billing charges and diagnostic codes. The clinical staff also received training on the elements necessary for documentation of clinical visits with varying complexity.

In addition to capacity building around specific skills needed in a third-party billing environment, deepening the staff's understanding of why the clinic was undertaking this process to create buy-in also played a critical role.

## XII. NEXT STEPS AND ASPIRATIONS

Denver Metro Health Clinic's long-term goals are to improve efficiencies within the clinic utilizing existing resources and to develop systems that would allow for diversified revenue within the clinic. Those involved in the planning process prioritized these strategies in order to ensure longevity of the safety net for the citizens of metropolitan Denver. These goals are in the process of being met through the implementation of a three-pronged work plan:

1. Understand the current cost for service delivery at the patient, not grantee, level and analyze current patterns of care and flow dynamics within the clinic. The goal is to provide excellent service that meets the patient's need while minimizing time and resources. Changes in patient flow have been studied and piloted in the clinic. The clinic staff anticipates implementing these new protocols in Winter 2012/2013 and is hopeful that they will result in a 20-30 percent increase in productivity without a corresponding increase in resources.

2. Establish the processes and procedures necessary to bill third party payers and to improve systems within the clinic. The Denver Metro Health Clinic is planning for the anticipated increase in patients with a payer source under the Affordable Care Act. This work is on-going in the clinic, but has shifted from creating overarching systems to finalizing the intricacies of inserting codes and tracking revenue.

3. Implement an income-based fee structure to help direct patients to appropriate levels of service within the clinic. While Denver Metro Health anticipates the revenue to be modest, it will aid in diversifying the clinic's funding stream while emphasizing the joint responsibility of the patient and provider in maintaining a viable safety net clinic. Administrators intend to implement this fee structure without deviating from the clinic's public health mission. No one will be refused a needed service due to an inability to pay. Though the fee structure has largely been determined, this will be the last piece to be implemented in the clinic allowing administrators to continue to establish buy-in with health care providers on staff and allowing all staff to communicate this change to their patients.

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## Denver County, Colorado - STD Data At-a-Glance

Chlamydia

- In 2010, Denver County, CO ranked 15th of all U.S. counties and independent cities for number of reported cases of Chlamydia, with 10,496 reported cases and an overall rate of 1,719.7 cases per 100,000 population.

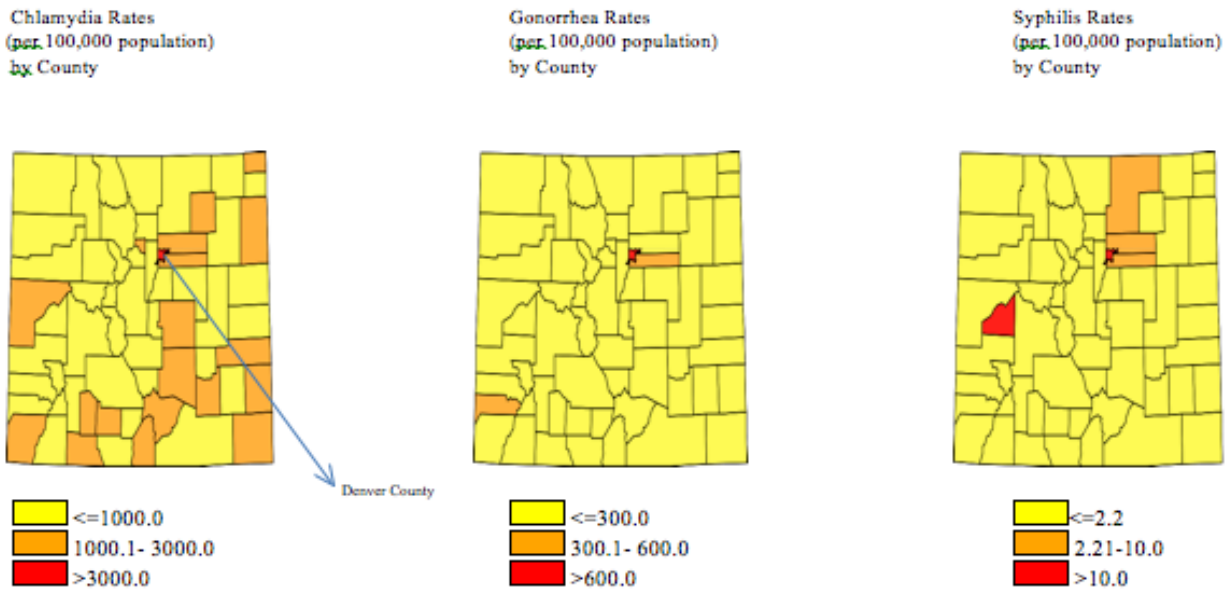
Gonorrhea

- In 2010, Denver County, CO ranked 34th of all U.S. counties and independent cities for number of reported cases of gonorrhea, with 1,732 cases and an overall rate of 283.8 cases per 100,000 population.

Syphilis

- In 2010, Denver County, CO ranked 31st of all U.S. counties and independent cities for number of reported cases of syphilis, with 99 cases and an overall rate of 16.2 cases per 100,000 population.

## Rates of Reportable STDs among Young People 15–24 Years of Age Colorado, 2010




## Recent Trends

- Statewide, among all people diagnosed with syphilis in 2010, 64% were also co-infected with HIV, an increase of 25% from 2006.
- In 2011, the majority of visits to Denver Metro Health Clinic, the largest STD clinic in the region, were made by individuals 20–24 years old (24% of all visits)
- Of all individuals seeking services at the Denver Metro Health Clinic in 2011, 38% were white, 37% Hispanic, and 16% were Black. In addition, 60% were residents of Denver County.

## Sources:

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# Case Study: Multnomah County STD Clinic

## I. OVERVIEW

Multnomah County STD Clinic is a full service STD clinic in Portland, Oregon. It is one of the last STD clinics in the area, after several others in neighboring counties closed their doors due to funding shortages and dwindling resources from local health departments. The clinic offers screening for Chlamydia, gonorrhea, syphilis, and HIV. An on-site lab tech completes wet mounts, urinalysis, stat rapid plasma regain (RPR), dark fields, and pregnancy tests. Rapid HIV testing is available for men who have sex with men (MSM), injection drug users, and partners of people living with HIV. The clinic also offers Hepatitis C antibody testing for individuals with a history of injection drug use. While the clinic does not provide ongoing family planning services, it does provide patients with emergency contraception, three months of oral contraceptive pills, or one Depo-Provera injection. Free condoms and other safer sex materials are frequently distributed. The clinic also provides immunizations for HPV, Hepatitis A, and Hepatitis B. The clinic does not offer pap tests, treatment for genital warts, or any non-STD related medical help. The clinic had 7,458 visits in fiscal year 2012, ending June 31, 2012.

The clinic also operates a satellite STD clinic at a community-based site called Pivot that serves the MSM community. Pivot is staffed by one nurse practitioner, two non-licensed providers, and one office assistant. Services are provided every Tuesday evening and Wednesday afternoon. Fees are waived at this site; however clients may grant permission for the clinic to submit a bill to their health insurance provider for reimbursement.

Even those who have a primary care physician or other place they receive most of their health care seek STD related care at the Multnomah County STD Clinic instead, not just because of confidentiality concerns, but also because of the culturally competent, non-judgmental, and emotionally safe care available to clients. This includes LGBT clients who may not feel comfortable or safe or may have experienced discrimination in another clinical setting.

A robust school-based health center system is available in a number of area high schools. These clinics offer access to a full range of STD-related services, which has contributed to fewer clients less than 19 years of age seeking services at the Multnomah County STD Clinic.

### Profile of Clients Served

The Multnomah County STD clinic seeks to serve the most at-risk populations, including men who have sex with men (MSM), youth under 24 years of age, symptomatic clients, and those who have had contact

with individuals infected with Chlamydia, gonorrhea, syphilis, and HIV. Individuals from these populations are considered to be priority clients and the clinic is able to see 71 percent of them within two days. Clients who are not from a priority population, including those who are asymptomatic, are usually scheduled within 3 or 4 days. Walk-in clients must wait until an opening is available from a missed or cancelled appointment of a priority client.

### Profile of Clients

| | | |
|---|---|---|
| **Gender** | Female | 25-30% |
| | Male | 70-75% |
| **Other** | MSM | 39% |
| **Age** | 24 and under | 20% |
| | 25 and older | 80% |
| **Ethnicity/Race** | Latino/Latina | 14% |
| | Caucasian | 64% |
| | African-American | 14% |
| | American Indian | 1% |
| | Asian/Pacific Islander | 4% |

### STD Profile

At the end of this section there is a chart explaining the STD profile of the local population.

### Key Questions

1. What role does your clinic play as a safety net provider?
2. What considerations emerge as you think about implementing a third-party billing practice while still upholding your mission as a safety net provider?

## II. FINANCIALS

### Budget

The Multnomah County STD Clinic's fiscal year runs from July 1st through June 31st. 2012.

In Fiscal Year 2012 the clinic had an operating budget of $2,274,000.

- $176,553 was billed to third-party payers of which $56,424 was reimbursed.
- $895,486 was charged to self-pay clients, of which $108,304 was collected in self-pay revenue.
- The remaining portion of the budget came from county general funds, a small state grant for partner services for surveillance and HIV prevention for community testing, research studies, and Ryan White Care funds for early intervention services.
- The clinics also receive state support for public health, which is a per capita allocated general tax fund, directed to core public health functions. The Health Department allocates these funds to the STD, communicable disease, and tuberculosis program divisions.

### Payment Options

The Multnomah County STD Clinic charges a $150 fee for regular male STD/HIV screening, without any discounts applied, and $150-200 for the regular female screening, without any discounts applied. A client may use his/her public or commercial insurance coverage. If the client does not have insurance coverage, the fee is on a sliding scale based on his/her income and household size.

In April 2011 a new rate policy took effect, requiring a minimum payment from clients contacted by Disease Intervention Service (DIS) because they are partners of infected persons. Previously, these clients could access services free of charge, however, as stated in the Multnomah County Health Department STD HIV Hepatitis C Standard Operating Procedure, published in April 2011, "there has been a growing need to increase clinic revenue to continue to provide the priority services that define the mission of the STD, HIV and Hepatitis C Program." These clients may authorize the clinic to bill their insurance provider for the screening, instead of paying out of pocket. The

Multnomah Health Department STD Manager clarified that the State STD Program Element, which articulates the programmatic and service deliverables, does not prohibit billing medical insurance for these clients, "as long as no client is turned away for inability to pay, and the messaging doesn't create a perception of a barrier to accessing care." The State Program will continue to provide medications for treatment of syphilis, gonorrhea, and Chlamydia at no charge.

Self-pay clients are assessed fees on a sliding scale. Those who were assessed a fee at the lowest end of the scale and thus received the biggest discount, are asked to pay a minimum of $20. While clients are asked to make a payment toward their balance, the clinic makes clear that services will be provided to all, regardless of ability to pay. If the client is unable to pay the entire balance due, the clinic provides envelopes for the client to submit payment at a later date, although no billing statements are ever sent to the client.

### Key Questions

1. What are the payment options currently available to your clients? How might implementing third-party billing practices ensure greater affordability for your clients?

## III. WHY BILL?

### Rationale for Third-Party Billing

The Multnomah County STD clinic is able to generate sufficient revenue through third-party billing and self-pay to help defray some of the costs of salary and benefits for two staff members which contributes to the overall financial health of the agency by diversifying revenue streams.

The clinic is able to bill third-party payers without incurring overly onerous administrative costs by leveraging the use of health department staff and infrastructure.

In addition, the clinic leadership believes that an active third-party billing practice demonstrates to policy makers and local leaders a good faith effort on the part of the clinic to contribute to their financial health and share in the cost burden.

### Key Questions

1. What would be the rationale for implementing a third-party billing practice in your clinic or in the STD clinic in your county?

## IV. HISTORY OF BILLING

The third-party billing practice has evolved incrementally over time. While there is not a record of the exact date that the clinic started billing, anecdotally, clinic staff recall that there has been a billing practice at least since the mid-80's. This started as a self-pay billing option and eventually included third-party billing.

The predecessor to the current program manager for Multnomah County Health Department's HIV, STD, Hepatitis C Program thought strategically about the provider levels in the clinic and the impact on third-party billing. She decided to gradually shift the balance from Registered Nurses (RN) and Licensed Practical Nurses (LPN) to mid-level providers, such as Nurse Practitioners and Physician Assistants, whose services were reimbursable by third-party payers.

## V. BILLING PROCESS—RELATIONSHIP WITH THIRD-PARTY PAYERS

A relationship building process is critical to a successful third-party billing practice. There are several steps that an STD clinic needs to take to be able to participate with a third-party payer and to increase their rate of return on claims submitted.

### Credentialing

Credentialing is a process by which providers who bill third-party payers for services provide documentation of the qualifications, experience, education, and licensure.

Early in the history of the clinic's billing practice, the staff learned that reimbursement checks from Blue Cross/Blue Shield were being sent to the clients instead of to the clinic because the clinic's health care providers were not credentialed with this insurance provider. The clinic then decided to undergo the process of credentialing the health care providers on staff with this insurer because it has a significant share of the market.

Today the clinic also credentials its providers with Care Oregon, a major Medicaid provider in the state but it chooses not to credential its providers with all insurance companies, because it is a time consuming process and clients have coverage from many other providers. The clinic will, however, submit a claim if a patient has coverage through a third-party payer with whom they are not credentialed, although the likelihood that the claim will be paid out decreases considerably.

### Contracting

The Multnomah County STD Clinic contracts with certain third-party payers through the Health Department billing office in order to become in-network providers. It currently has a contract with Kaiser Permanente Medicaid and the local Medicaid managed care organizations. As they do not have contract with other third-party payers, they are considered out-of-network, decreasing the rate at which the claims will be reimbursed.

#### Key Questions/Considerations

1. What are the Medicaid managed care organizations serving your area?
2. What would be the value of having a contract with the third-party payer?

## VI. BILLING PROCESS-PATIENT FLOW

Supporting a third-party billing practice is an "all-hands-on-deck" proposition. From the moment a client calls or walks in, to registering, to being seen by a provider, to checking out, everyone who comes in contact with a client has a role to play. Depending on their role, staff and providers in the clinic are responsible for educating clients, obtaining relevant information, and/or entering that data into the EPIC practice management system. In a sense, all staff and providers can be considered billing staff.

### Intake

The registration form (on the next page) gathers standard demographic information, but also asks the questions related to health insurance coverage. All of the information requested in the registration form is voluntary and no proof of income or insurance is required, unless a client indicates a willingness to have his/her insurance billed.

In 2011 Multnomah County STD Clinic clients reported the following insurance coverage:

- 89 percent did not have insurance or did not want to bill insurance
- 5 percent has commercial insurance
- 5 percent has Medicaid
- 1 percent had Medicare

### Provider Encounter

At the time of the encounter, the provider who sees a client is responsible for noting the ICD-9 code(s), which indicate the diagnosis, and the CPT code(s), which indicate the medical services provided.. Correct coding is critical to ensuring claims are successfully processed with third-party payers. Each third-party payer has slightly varying standards about coding. Multnomah County STD Clinic maintains paper medical records so each patient encounter is recorded on a paper superbill. The clinic has designed a custom superbill that lists the necessary patient information, along with

On the following page is the text of the intake form used during this process.

**Registration Form**

The Multnomah County Health Department requires that we collect client demographic data. This information is confidential and allows us to continue to provide quality services.

**Last Name**_____ **First Name**_____ **MI**_____

**Date of Birth**_____

| **Ethnic Group** | **Race** | | **Gender** |
|---|---|---|---|
| Hispanic | Asian | Alaskan Native | Female/Male |
| Non-Hispanic | Black | American Indian | **Transgender** |
| Unknown | White | Native Hawaiian | Male to Female |
| | Unknown | Pacific Islander | Female to Male |

**Permanent Address**_____ **Apt #**_____

**City**_____ **State**_____ **Zip Code**_____

**Temporary Address**_____ **Apt #**_____

**City**_____ **State**_____ **Zip Code**_____

**Home Phone Number**_____ **Cell Number**_____
**Message Phone Number**_____

**Can we send mail to this address and/or call these numbers? YES NO**

***If you answered NO to the question above, what is the best way to contact you if we need to? Please circle one below. If we need to contact you we will be discreet.**

**1) Mail-permanent address 2) Mail- temporary address 3) Home phone 4) Cell phone**
**5) Message phone 6) No contact 7) Other** _____

**Do you have medical Insurance? YES NO**

**Are you on Oregon Health Plan? YES NO**

**Do you want us to bill your medical insurance? YES NO**

**What is your yearly gross income** _____ **(REQUIRED)**
***(All wages, unemployment, government aid)***

**Number of People supported by this income, including you** _____

**PLEASE RETURN TO THE RECEPTIONIST**
**THANK YOU**

the diagnostic and procedural codes most used in the clinic. This streamlines the process of coding, ensures uniformity, and minimizes any misunderstandings that might come from the clinic assistant entering the data in the computer system.

### Check Out

If a client has Medicaid, the registration staff verifies coverage in the Medicaid Management Information System (MMIS). The Primary Care Centers run by the Health Department have eligibility specialists on staff who can enroll eligible clients, but unfortunately, the Multnomah County STD Clinic doesn't have the same capacity.

Clients who have either Medicaid or Medicare are not required to make a payment at the time of service, however, clients with commercial insurance are responsible for any co-pays and payment for services not covered in their plan.

For clients who don't have insurance, or don't wish to use their insurance, the amount owed is assessed on a sliding scale. The minimum payment is $20, and if they are unable to pay at the time of service, the balance goes on their account and they are given envelopes to submit a payment at a later date. No statement is ever sent to the client's home. If the client does claim insurance coverage, clients pay their co-pay and for any services not covered by their insurer.

If the claim that the clinic submits is rejected, the balance is added to the client's account according to the sliding fee scale. Most commercial insurance companies and Medicare will send an Explanation of Benefits (EOB) to clients informing them that a claim was submitted, what services were covered, and what amount (if any) the client is responsible for.

### Key Questions/Considerations

1. What kind of modifications would you make to the way you move patients through your clinic?

## VII. BILLING PROCESS- CLAIMS PROCESSING

Once the information from the client's visit has been entered in EPIC Practice Management by the clerical staff of the Multnomah County STD Clinic, the Multnomah County Health Department medical billing office staff takes over. The clinic has an agreement with the medical billing office of the Health Department to complete the billing process. The Multnomah County STD Clinic greatly benefits from the existing Health Department infrastructure. The Health Department medical billing staff receives County general funds to provide support services to clinics within the Health Department. There are only four staff members in the Department's billing office who are responsible for handling a high volume of claims for both the STD clinic as well as seven primary care sites. In 2011, there were 8,862 encounters billed from the STD clinics and tens of thousands for primary care.

Through EPIC Practice Management, the billing process is mostly automated. Once an encounter is submitted in EPIC with insurance attached the claim enters a work queue in another system called Gateway, which is a national clearinghouse. Gateway reviews the encounter for any potential errors. Once the encounter is cleared, Gateway then submits the claims to the third-party payers. Gateway charges approximately 5 percent of all medical services billed which is covered by the Multnomah County STD Clinic's operating budget. Working with the clearinghouse enables the Multnomah County Health Department to meet Medicaid's mandate to submit claims in a 5010 format.

Claims may be rejected for a number of reasons: the service is not covered on the client's health plan, the provider is not in network, the person hasn't met their deductible, coverage was not in effect on the day of service, the client had reached the maximum of their benefit, or billing errors. Receiving regular reports on why claims are denied assists with ongoing quality improvement. Due to the volume of claims throughout

the HD the Multnomah County medical billing office doesn't generally follow up on rejected claims from the STD clinic.

**Key Questions**

1. Would you opt for a paper based or electronic billing system? What would be the advantages/disadvantages of either option in your clinic?

## VIII. PARTNERSHIPS, COLLABORATIONS AND LEVERAGING RESOURCES

The Multnomah County STD Clinic is able to sustain a third-party billing and revenue generation system because of a number of supporting factors and partnerships. The clinic relies on the health department to manage the billing and claims process using the EPIC system but even with the clinic and its seven primary care sites, the Multnomah County Health Department did not have sufficient claims processing volume to warrant purchasing an entire system on their own.

The Department was able access an existing system through participation in the OCHIN collaborative. OCHIN is "one of the nation's largest and most successful health information networks, OCHIN is nationally recognized for its innovative use of Health IT to improve the integration and delivery of health care services across a wide variety of practices—with an emphasis on safety net clinics and small practices as well as critical access and rural hospitals." OCHIN supports optimizing practice management (PM) and electronic health record (EHR) products as well as training staff and practitioners on how to use these resources. OCHIN members are primarily community health centers that benefit from such collaborations of scale and are located in Alaska, California, Montana, Nevada, North Carolina, Ohio, Oregon, Texas, Washington, and Wisconsin.

While the EPIC system that the Health Department access through OCHIN can be used to manage medical records, Multnomah County STD clinic does not use the technology for this purpose. When it adopted the system about nine years ago, the technology was relatively new and administrators were uncertain about the reliability of the security features. Out of concern for patient confidentiality, they opted only to use EPIC for billing but to continue to manage client medical records in-house with a paper-based system. They would like to be able to manage patient health care records in house with an electronic health records system but can't afford the upgrade fees. At the time that they adopted the system, the cost was covered by the health departments and shared across all programs. While opting into the EPIC system with a collective of other providers allowed access to the technology and helped Multnomah County STD Clinic overcome some of the financial barriers, there are some challenges to being one of many users in a large system. For example, while the clinic allows patients to describe themselves as transgender male-to-female or female-to-male, the shared EPIC system does not. This lead to at least one claim being flagged when a patient defined as male was given the diagnosis of Vaginitis which only females can have. The system administrator at Multnomah County STD Clinic has put in a request to make this modification in the system.

**Key Questions**

1. What resources are available within your own health department that might be able to support a third-party billing practice?

## IX. STAFF AND PROVIDERS

The following providers see clients at the Multnomah County STD Clinic and are able to bill for services rendered:

- One Physicians Assistant (80 percent FTE)
- Two nurse practitioners (80 percent FTE)
- One lead practitioner (50 percent FTE)

There are also a number of community health workers who are responsible for seeing those clients who are coming in for a "just checking" appointment, which offers STD testing using self-collected specimens. These community health workers also see asymptomatic clients, perform needle exchange, and community testing.

The clinic has five office assistants who schedule appointments, answer calls, register clients, enter client data into the data management system, and check patients out, among other activities.

## X. MESSAGING TO CLIENTS

The Multnomah County STD Clinic informs clients at several points about the possibility of billing their insurance provider. The clinic's website informs potential clients that the following payment options are available to them: "cash, checks, VISA, Mastercard, and some insurance including the Oregon Health Plan. There are some tests that you may be required to pay on the day of your visit."

Clients also receive a brochure at check in that states: The cost of your visit will be determined on a sliding fee scale. There are some tests that you may be required to pay for on the same day as your visit. We accept Care Oregon/OHP and some private insurance. You may pay at the end of your visit in cash, check, or credit card.

### Key Questions

1. What are the ways that you currently communicate with clients? How could you use those existing channels to inform your clients about the opportunities and responsibilities of billing third-party payers for STD related services?

## XI. CAPACITY BUILDING

Capacity building is a critical element to supporting a third-party billing practice. When a new office assistant is hired, he/she receives on-site training from a senior office assistant. Medical billing staff from the Multnomah County Health Department also trains the STD clinic staff on an annual basis to update staff knowledge and answer questions; they are also on call throughout the year for any questions that may arise. Staff often ask questions about what certain codes mean, how to interpret an insurance card, how to enter data into the EPIC Practice Management, and what kind of insurance they can accept.

### Key Questions

1. What kind of capacity building would be useful in order to initiate a third-party billing practice?

## XII. NEXT STEPS AND ASPIRATIONS

Multnomah County STD Clinic would like to have access to more options for electronic verification of insurance coverage. A significant number of clients weren't insured at time of service, so claims were ultimately denied. If this information had been available at the time of service, clinic staff would not have wasted time and resources generating a claim or attempting to bill the third-party payer.

Staff would also like to see better coverage for STD clinical services and preventive care. Expanded care options through the Affordable Care Act makes this more of a reality.

## Multnomah County, Oregon - STD Data At-a-Glance

Chlamydia

- In 2011, Multnomah County, OR ranked 1st of all counties in Oregon for number of reported cases of Chlamydia, with 3,987 cases and an overall rate of 546.1 cases per 100,000 population.

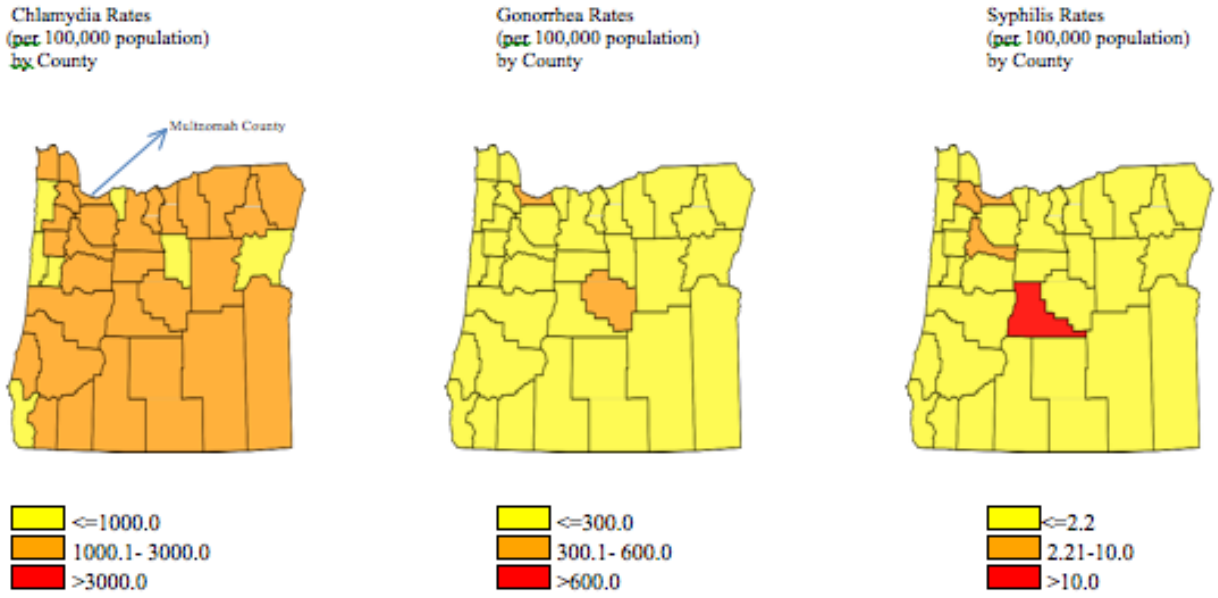
Gonorrhea

- In 2011, Multnomah County, OR ranked 1st of all counties in Oregon for number of reported cases of Gonorrhea, with 892 cases and an overall rate of 122.2 cases per 100,000 population.

Syphilis

- In 2010, Multnomah County, OR ranked 66th of all U.S. counties and independent cities for number of reported cases of Syphilis, with 44 cases and an overall rate of 6.1 cases per 100,000 population.

## Rates of Reportable STDs among Young People 15–24 Years of Age Oregon, 2010




## Recent Trends

- Between 2003 and 2010, Chlamydia rates have increased in Multnomah County from 342 per 100,000 population to 486 per 100,000 population, while Gonorrhea rates have remained flat.
- In 2010, females 15–24 years old had the highest rates of Chlamydia of any group in Multnomah County.
- While Gonorrhea rates were twice as high in 2010 for females rather than males among 15–19 year olds in Multnomah County, they remained consistently higher for males between 20-40 years old.
- In 2010, the rate of Gonorrhea was more than 4 times higher for African Americans than whites in Multnomah County.
- In 2010, nearly 90% of Syphilis cases in Multnomah County were among men who have sex with men (MSM), of whom more than 50% were co-infected with HIV.

## Sources:

Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2010. Available at: http://www.cdc.gov/std/stats10/default.htm
Multnomah County Health Department. 2010 STD/HIV Hepatitis C Program Annual Report. Available at: http://web.multco.us/sites/default/files/health/documents/std-hiv_annual_report_2010.pdf
Oregon Public Health Division. Oregon Cases & Incidence of Early Syphilis, Gonorrhea and Chlamydia by Year and County. Available at: http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/annrep.aspx.


# Case Study: Red Door Services

## I. OVERVIEW

Red Door Services, located in Minneapolis, MN, is a full service STD clinic that has been providing confidential, non-judgmental and professional sexual health care to the community since 1970. Red Door is the largest HIV/STD testing site in Minnesota, providing testing, treatment, and health education around STDs, Ryan White-funded HIV medical care for the uninsured, as well as pregnancy prevention and targeted HIV/STD prevention programming.

In 2007, Red Door joined Refugee Health Services and TB Control Services in forming the Hennepin County Public Health Clinic, though Red Door Services has continued to retain its unique identity. The Hennepin County Public Health Clinic is a multi-lingual, multi-cultural, multi-site health center through which clients can access screening and treatment for STDs, HIV testing, TB control services, refugee health screening, immigration exams, family planning services, and Ryan White HIV services for qualified individuals who are HIV-positive and not currently in care. There are four sites, each clinic operates as its own entity, with its own providers, however, by partnering the clinics benefit from shared infrastructure and shared administrative staffing.

Many Red Door services, including STD screening and treatment, are available on a walk-in basis. An appointment is required for pregnancy prevention services, including pelvic exams and consultations for contraceptives. Appointments are also needed for Ryan White Services for early HIV care.

### Profile of Clients Served

| | | |
|---|---|---|
| **Age** | 15-24 year olds | 30-40% |
| | 25-39 | 40% |
| | 40-49 | 10% |
| | 50+ | 10% |
| **Ethnicity/Rage** | Latino/Latina | 30% |
| | Caucasian | 31% |
| | African-American | 14% |
| | American Indian | .5% |
| | Asian/Pacific Islander | 1.3% |
| | | |

Approximately 20-25 percent of the clients seen at the clinic are men who have sex with men (MSM).

### STD Profile

At the end of this section there is a chart explaining the STD profile of the local population.

### Key Questions

1. Is your clinic a stand-alone categorical STD clinic, or are you co-located with another clinic?
2. What would be some of the advantaged and disadvantages of co-locating your STD clinic into a larger setting?

## II. FINANCIALS

### Budget

The operating budget for Red Door services falls between $400,000 and $500,000 annually. Red Door Services has a few general operating grants that are well-funded for the foreseeable future, including a counseling and testing grant from the CDC through the Minnesota Department of Health, however, other grant funding for prevention services are dramatically shrinking. Other funding sources include revenue from third-party billing (public and commercial insurance), patient fees and donations, and a portion of the county property tax. The breakdown of funding is as follows:

- Third-party billing revenue 33 percent
- Fee for service 12 percent
- County 55 percent

Red Door Services sets goals for revenue generation in its budget each year, and projects income from third party reimbursements, the Prepaid Medical Assistance Program state plan, and private pay collection from patient fees.

### Payment Options

Red Door Services seeks to capture as much revenue as possible without worrying about profit. The following payment options are available to Red Door Services' clients:

- Third party billing (public and commercial insurance)
- Private payment on sliding scale
- Donations from clients

No one is denied service based on inability to pay and the clinic does not collect co-pays or bill for balance of the payment due.

In March 2012, approximately 40 percent of Red Door Services' patients had insurance (commercial or public) and 60 percent were self-paying. Of those who were self-paying, 85percent claimed an income level of $0 and were therefore charged at the lowest level on the sliding scale. Approximately 50 percent of those in the no charge category, however, made a contribution of $5 to $15. In the month of March 2012, for example, the clinic received $330 in donations from 70 individuals who received services. While patient donations do not approach the actual value of the services provided, the practice does help establish the precedent that STD related services are not, in fact free.

### Key Questions

1. What does your budget currently look like? What projects or services have you been unable to move forward with because of budget shortfalls?

## III. WHY BILL?

### Rationale for Billing

Red Door Services prides itself on operating an efficient and effective third-party billing practice. It strives to optimize its billing system in order to maximize the impact and ensure long-term sustainability of the clinic. Clinic administrators realize that generating revenue by billing third-party payers means that they are not at the mercy of budget shortfalls and can carry out a robust level of service of their clients. In 2011, Red Door Services had 12,277 patient visits and was able to generate 33 percent of its budget with revenue generated by third party billing.

Red Door is able to accomplish this through a finely tuned system complete with Electronic Health Records (EHR) and dedicated staff. Administrators work to build the capacity of their providers, educate patients, monitor and tweak the EHR system, and respond to

the ever-changing requirements of each payer. Third-party billing does not, however, impact the clinic's role as a safety net provider as the clinic continues to see clients regardless of their ability to pay. The practice does enable them to increase the financial resources available to the clinic, and ensure that services will continue to be available to all who require them, including those without health insurance or who are unable to afford out-of-pocket payments.

**Key Questions**

1. What is your elevator pitch (30 second argument) to make the case for why your clinic should bill third-party payers?
2. Effective advocacy strategies often speak to both the head and the heart? What are two reasons that make a logical argument, and what are two reasons that offer a compelling emotional one?

## IV. HISTORY OF BILLING

While Red Door Services did not begin billing its clients until around 1997, the Refugee Service Clinic, one of the clinics that was eventually co-housed with Red Door Services, had begun to bill sporadically by 1985. An administrator at Refugee Services was hired to improve the billing practice and initiate TB services. Red Door Services staff, however, was very reluctant to bill clients out of concern that it might drive clients away. In fact, even after the Director of the Public Health Department issued a mandate for Red Door Services to begin billing, it did not take effect. With time, progress was made and Red Door began billing by 1997.

The County developed a policy that stated that county funds, which were derived from property taxes, would be the payer of last resort. This set the stage for improving and expanding the billing practice while continuing to serve as a safety net provider.
The clinic contracted its billing out and operated a dual/parallel electronic health records system: CLEO system for patient demographic, medical information, lab results and scheduling and Versus system (used-by the external billing specialist) which had demographic, billing, and payment information, while still maintaining a paper-based system for medical records.

In 2009 they adopted the EPIC Electronic Health Records (EHR) system through a collaboration with the Hennepin County Health Care System, a public subsidiary of the county that operates numerous medical centers and clinics in the area. This moment marked a significant shift in the effectiveness and efficiency of their billing practice. Their revenue increased by 38 percent after switching to the EHR system. When relying on the paper process, the provider had to remember to code everything and submit the form and there was more opportunity for error.

Many clinics and programs are too small in scale to be able to afford an EHR on their own, but may have access through a consortium of agencies and service delivery sites, a county operated system, such as one operated by a large hospital, and can embark cost sharing. This cost sharing enabled Red Door to have access that might otherwise have been cost prohibitive.

While some clinics fear that transitioning to EHR is too expensive due to additional staffing costs, Red Door Services was able to transition existing staff who had an interest in taking on a new challenge and an aptitude for adapting to a new practice. The electronic system marked a significant decrease in handling paper records, so rather than hire new staff, the clinic was able to transition existing employees into new roles. As staff transitioned over the years, the new hires were made with consideration of Health Information Technology (HIT) training and skills, though this was not a requirement during the initial transition.

Within the Epic EHR system used by the Hennepin

County Consortium, there is a service area designated for public health and clinical services that represents the entire Hennepin County Public Health Clinic. Within that broader service area, each of the individual clinics that make up the Hennepin County Public Health Clinic (Refugee Services, Red Door Services, TB Services and Homeless Health) has a separate revenue site, which enables them to bill for services rendered by that particular clinic. By having distinct revenue sites, the clinics can enjoy the benefits of shared infrastructure and physical space while maintaining separate accounting.

### Key Questions

1. How do you maintain patient records?

## V. BILLING PROCESS-RELATIONSHIP WITH THIRD-PARTY PAYERS

### Credentialing

Credentialing is a process by which health care providers who bill third-party payers for services provide documentation of their qualifications, experience, education, and licensure. The credentialing is handled by the billing staff at Red Door Services. The health care providers at Red Door Services, all of whom are Nurse Practitioners, are credentialed with the core set of third-party payers that are most commonly seen at the clinic. Whenever a new provider is hired, he/she is credentialed with Red Door's cohort of third-party payers. The credentialing must be renewed for every provider on an annual basis.

### Contracting

Red Door Services only has contracts with the third-party payers held most commonly by the clients who receive services. Hennepin County has a contracts office which handles the outreach to the third-party payers and develops the relevant contracts. When a new third-party payer with whom Red Door Services does not have a contract is seen frequently enough to merit a contract with that payer, the billing department staff contacts the payer to enter into a new contract

### Key Questions

1. Do any of the healthcare providers in your STD clinic already have experience with credentialing?

## VI. BILLING PROCESS-PATIENT FLOW

### Intake

When a client creates an appointment, either as a walk-in or over the phone, the registration staff gets basic demographic information as well as information about insurance coverage. He/she then enters this data into the electronic health records system and creates an appointment on the schedule.

Upon arrival the patient checks-in at the front desk and any missing information is collected and entered into his/her record.

### Provider Encounter

The provider calls the client back to a consultation room and opens his/her chart in the electronic health records system. The provider documents the diagnosis (using ICD-9 codes) and procedures performed during the visit (using CPT code) directly into the electronic encounter form, orders lab work, and indicates level of service charges.

### Check Out

Upon checking out, clerical staff verifies the charge and any fees owed. The charge is assessed on a sliding scale if the client doesn't have insurance coverage.

**Key Questions**

1. What steps need to be taken to ensure that your intake procedures would support a third-party billing practice?
2. How might the role of the clinic providers change with the implementation of a third-party billing practice?

## VII. BILLING PROCESS- CLAIMS PROCESSING

After the provider enters the data from the client's visit, the record generates a claim. The EHR has internal "work queues," that catch discrepancies and hold claims for either the billing team or the provider to fix.

For example, a rule that might stop a claim would be charges without a diagnosis or charges missing a provider designation. The billing supervisor at Red Door can also create a rule to stop 20 percent of claims from a particular health care provider in order to have a general audit ensuring compliance with the billing protocols. The software also allows the billing supervisor to establish a rule that stops 100 percent of claims from a new health care provider to ensure that he/she is inputting all of the necessary information and that there are no conflicting codes being used. This process helps to build the capacity of the provider.

A claim is then "scrubbed," meaning that any errors are corrected, to increase the likelihood that the claim will be accepted by payer. It is automatically submitted to the county billing office. On average this happens within three days of the patient's visit. The County billing office then submits claims to a clearinghouse for a final review and to ensure proper formatting before they finally go to the third-party payer for processing.

If a claim is accepted, the reimbursement is sent through electronic remittance to the county finance department and then posted to the patient's account within Red Door Services—99 percent of payer remittances are electronic, with only the occasional paper check. Denied or rejected claims are posted to a work queue to be "scrubbed" again. Billing staff follows up with the insurer on claims that received only partial payment or no response.

**Key Questions**

1. Would a paper based or electronic billing system be a good fit for your STD clinic?

## VIII. PARTNERSHIPS, COLLABORATIONS AND LEVERAGING RESOURCES

Red Door Services leverages the many resources available to it through the Health Department and others in the community to support its third-party billing practice.

Hennepin County Public Health Clinic is the umbrella clinic under which Red Door Services is located. Being co-located with three other clinics enables Red Door Services to maximize the resources available, such as shared administrative staff, shared physical space, and a shared in-house lab including others.

The Hennepin County Contracts Department spearheads development of contracts with third-party payers, relieving some of the administrative burden from staff at Red Door Services. The health department's billing department submits the completed claim to the clearinghouse and posts reimbursements to the account of Red Door Services, ensuring compliance with the billing requirements of third-party payers and streamlining the revenue cycle.

Finally, through an agreement with the Hennepin County Medical Center (Hospital), which owns the EPIC system that Red Door Services is an affiliate of,

Hennepin County Public Health Clinic is able to share costs.

### Key Questions

1. How might you leverage existing resources among community partners or within your local or state health department to support a third-party billing practice?

## IX. STAFF AND PROVIDERS

There is one billing team of five people (three full-time, two part-time) for the entire Hennepin County Public Health Clinic that oversees coding, medical billing, credentialing, coding errors, and claim denials. Credentialing is handled entirely in-house and is the responsibility of the billing supervisor. Prior to making the switch to a single, integrated system, claim reimbursements were posted through paper checks from the third-party payers and had two parallel systems. This required significantly greater staff time to manage.

When transitioning to in-house billing, Red Door Services looked for staff who were interested and wanted to learn more about it. Some handled the transition well while others struggled a bit. It was a challenge for some to let go of how things were done before and trust that the new system would work. Initially, staff maintained both the paper and electronic system, but soon dropped that practice.

Moving their billing process in-house afforded them greater oversight and control. From the moment a patient calls to make an appointment or walks in the door to the moment that a claim is paid and directly deposited to the clinic's account and credited to the patient's account, Red Door Services has oversight and can impact the efficiency of the process. Whereas claims processed by the out-of-house billing specialist were batched and submitted every one to two months, current claims processed in-house are submitted to payers daily, and payment can be credited within days. This means that the money available to the clinic is more consistent with fewer surges and shortfalls.

### Key Questions

1. Would it suit your clinic best to manage the third-party billing practice entirely in-house and or would it work best to work with an external consultant?

## X. MESSAGING TO CLIENTS

Red Door Services uses a variety of media to raise awareness about the possibility of a client using his/her insurance coverage to pay for services. However, it is also important to explain, that while third-party billing is an option, clients will receive services regardless of coverage and ability to pay. Messaging to clients helps to create clear expectations about third-party billing.

The following messages are on the Red Door Services website:

> "STD testing services are provided regardless of a person's ability to pay, and charges are based on a sliding-fee scale. We accept most forms of health insurance, so please bring your insurance card. Donations are also welcome."

> "WHAT IS THE COST OF AN HIV TEST? A donation of $20 is requested for an HIV test, though no one is ever turned away due to an inability to pay."

> "Many of our services are available on a walk-in basis and are provided regardless of a person's ability to pay. We accept most insurance and are able to provide sliding fee scales for low-income as well as uninsured individuals."

A similar message is communicated through a brochure about the clinic:

> "Services are provided regardless of a person's ability to pay, and charges are based on a sliding-fee scale. We accept most forms of health insurance, so please bring your insurance card. Donations are also welcome."

**Key Questions**

1. What would be the most important information to convey to your clients about third-party billing? What are three methods of delivery that would reinforce that message?

## XI. CAPACITY BUILDING

Most billing staff took medical and billing coding classes when Red Door Services moved the billing practice in house. While clinics are not required to have a coding specialist with a Health Information Technology (HIT) degree on staff in order to implement a third-party billing practice, Red Door Services found that this was helpful, particularly in supporting day-to-day learning of the other billing staff.

Red Door prioritizes training and capacity building, both for staff who manage the billing system and for health care providers. Capacity building at Red Door Services occurs through formal training workshops conducted by representatives from EPIC, the electronic health records company whose software the clinic uses, as well as on-going in-house capacity building during weekly meetings, one-on-one with practitioners, and tip sheets created by the billing manager.

Billing staff also carefully analyze why claims are rejected, and rely on several review "queues" along the way to check progress. They learn from any problems encountered and tweak the rules set up in the EHR. While it requires an investment of time to track claims and assess whether or not they have been created properly, this investment yields significant returns.

Managing the EHR also requires ongoing training to keep up with evolving rules and regulation, the proper way to review and audit records and how to manage work flows or work queues on the EHR system. Red Door Services has also found the Health IT webinars offered by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HRSA) to be useful resources in the capacity building toolkit.

**Key Questions**

1. What are your current capacity building priorities?

## XII. NEXT STEPS AND ASPIRATIONS

Red Door Services seeks to continue to improve its ability to accurately capture third-party payer information from clients. Staff would also like to help those clients who don't have health insurance coverage access any public programs for which they qualify.

NCSD
National Coalition of STD Directors
*Promoting Sexual Health Through STD Prevention*

## Hennepin County, Minnesota - STD Data At-a-Glance

Chlamydia

- In 2010, Hennepin County, MN ranked 46th of all U.S. counties and independent cities for number of reported cases of Chlamydia, with 5,242 reported cases and an overall rate of 453.4 cases per 100,000 population.

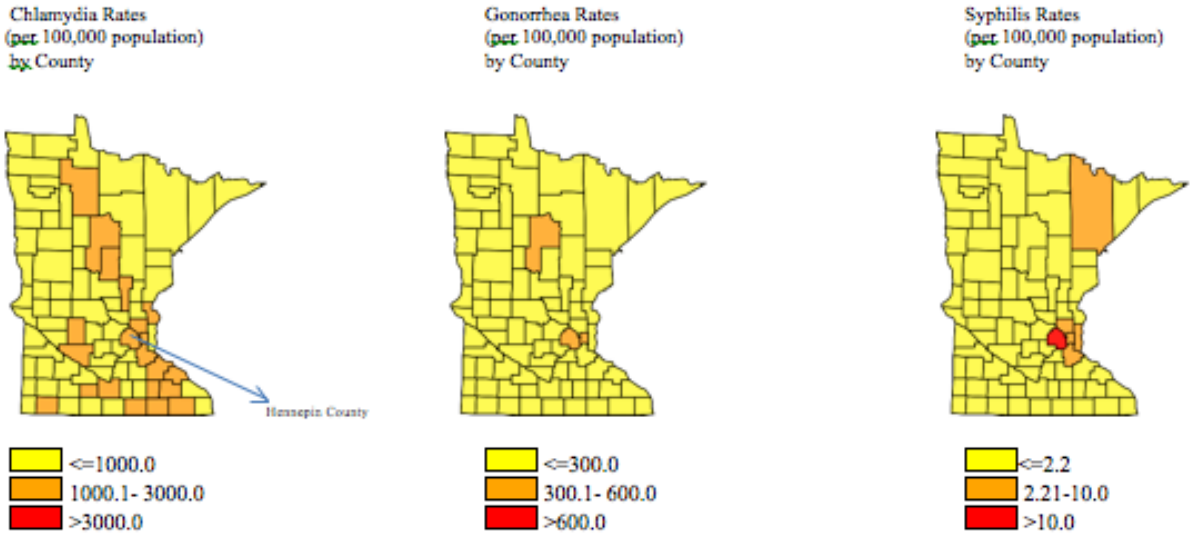
Gonorrhea

- In 2010, Hennepin County, MN ranked 63rd of all U.S. counties and independent cities for number of reported cases of Gonorrhea, with 1,073 cases and an overall rate of 92.8 cases per 100,000 population.

Syphilis

- In 2010, Hennepin County, MN ranked 32nd of all U.S. counties and independent cities for number of reported cases of Syphilis, with 99 cases and an overall rate of 8.6 cases per 100,000 population.

## Rates of Reportable STDs among Young People 15 - 24 Years of Age Minnesota, 2010




## Recent Trends

- The majority of all Chlamydia, Syphilis, and Gonorrhea cases in Minnesota in 2011 were in residents of Minneapolis or the Suburban area (defined as the 7-county metropolitan area, including Hennepin county and excluding the cities of Minneapolis and St. Paul).
- The greatest increase (15%) in Chlamydia rates between 2010 and 2011 occurred in the Suburban area.
- Statewide, the population with the largest increase (20%) in Chlamydia rates between 2010 and 2011 were American Indians.
- Men who have sex with men (MSM) account for 88% of all Syphilis cases in Minnesota and 42% of all Syphilis cases in 2011 were located in the city of Minneapolis.
- Statewide, adolescents and young adults (15––24) accounted for 69% of Chlamydia cases and 65% of Gonorrhea cases in 2011.

## Sources:

Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2010. Available at: http://www.cdc.gov/std/stats10/default.htm
Minnesota Department of Health, STD and HIV Section. 2011 Sexually Transmitted Disease Statistics. Available at: http://www. http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/stdreport2011.pdf


# Case Study: Philadelphia High-School STD Screening Program

## I. OVERVIEW

The Philadelphia High-School STD Screening Program is operated by the Philadelphia Department of Public Health STD Control Program in collaboration with the School District of Philadelphia. Philadelphia High-School STD Screening Program delivers an educational program on Chlamydia and gonorrhea to approximately 30,000 high school students each year, offering optional, confidential testing free of charge to the students in addition to the educational outreach. Approximately half of the students choose to be tested.

Collaboration between the Philadelphia Department of Public Health STD Control Program and the Family Planning Council, a non-profit organization with extensive expertise in third-party billing, was instrumental in launching a third-party billing practice for the school-based screening program. This approach demonstrates the possibility of third-party billing at scale, reaching significant numbers of students, and maximizing the sustainability of the outreach program. It also represents the potential synergies of reaching out to local partners.

### Profile of Clients Served

The Philadelphia High-School STD Screening Program (PHSSSP) targets students in ninth, tenth, and eleventh grade in all public high schools in the city. This includes magnet schools, music schools, and academic school, as well as disciplinary schools.

STDs reached epidemic proportions among adolescents in Philadelphia in 2000 with the city having significantly higher disease rates than either the national average or rates in other comparable cities. In 2010, the Philadelphia Department of Public Health identified a 38 percent increase in gonorrhea infections and a 7.2 percent increase in Chlamydia among adolescents ages 15–19, when compared to the previous year. In fact, one in eight teenage girls, in that age group in Philadelphia, was diagnosed with either Chlamydia or gonorrhea in 2010.

Moreover, the rate of Chlamydia among those ages 15–19 in Philadelphia is 3.5 times the national rate in the same age group and the rate of gonorrhea among that age group is 3 times the national rate. Among younger teens, those ages 10–14 in Philadelphia have Chlamydia rates that are 5.3 times higher than their peers nationwide and gonorrhea rates that are 4 times the national rate.

### STD Profile

At the end of this section there is a chart explaining the STD profile of the local population.

### Key Questions

1. Do you currently bill a third-party payer for any services in an off-site outreach program or would you be interested in setting up such a system?

## II. FINANCIALS

### Budget

The annual cost of the High School screening program is approximately $1,000,000. This includes staff, laboratory testing, treatment of positive clients, and related materials and expenses. Approximately 15–20 percent of this cost is generated by billing with the balance coming from a variety of other sources.

From 2004–2012, Medicaid managed care organizations have provided $1,056,257 to this program in reimbursements for the delivery of services. PHSSSP is now able to generate approximately $150,000 annually in revenue, although this does not cover all of the costs associated with the program (see above).

### Payment Options

No charge is assessed directly to the students at the time of testing, and they are not directly responsible for any costs associated with the screening. A student may opt to be tested whether or not he/she has insurance coverage, and he/she can be tested and choose not to have a charge submitted to his/her insurance provider.

## III. WHY BILL?

### Rationale for Third-Party Billing

The scale of the Chlamydia and gonorrhea epidemic among adolescents in Philadelphia requires extensive and ongoing screening and education to the target population. Third-party billing ensures the stability and sustainability of this outreach and screening program to this high-risk population.

In 2011, approximately half of the students who attended outreach events chose to be screened, and of those students, approximately 78 percent gave consent for their third-party payer to be billed in 2011. The program is also seeing a high rate of payment from the three third-party payers with whom it works, receiving reimbursement of almost 90 percent of total charges.

### Key Questions

1. What rationale might you give to implement a third-party billing practice for your outreach program?
2. Who might be skeptical about moving forward with third-party billing? What rationale would they find most compelling?

## IV. HISTORY OF BILLING

In 2004, realizing that the testing performed through the PHSSSP could be eligible for reimbursement, Philadelphia Department of Public Health STD Control Program capitalized on its existing relationship with the Family Planning Council in Philadelphia to develop a third-party billing practice. Third-party billing for the school-based screening was pilot tested, and in the second year of the program, was implemented across the board.

The PHSSSP chose only to bill Medicaid managed care providers for several reasons. First, a significant segment of the student population had Medicaid coverage ensuring viability of scale. Moreover, Medicaid coverage can be verified through the Pennsylvania Department of Public Welfare eligibility rosters without proof of coverage from the student. Finally, as there is not patient liability/ cost sharing, Medicaid does not send out Explanation of Benefits (EOB) statements to the primary account holder, usually a parent or guardian, eliminating any potential confidentiality and privacy concerns.

In 2004, the Medicaid Managed Care Organizations in Philadelphia agreed to reimburse the Philadelphia Department of Public Health for tests provided to

students who were enrolled as members in their plans. Due to stringent funding guidelines, any revenue generated must be directly channeled back into the program. This projected revenue is accounted for when crafting the annual funding proposal for the school screening program. The program administrators noted that revenue from third-party billing can't be used for other expenses unrelated to program delivery.

Critical to the success of this initiative was the cooperation of the Medicaid Managed Care Organizations (MCO) in Philadelphia. To ensure their support, the Philadelphia Health Commissioner at the time, John Domzalski, met with the heads of the MCOs to map how the school-based screening program would benefit all involved. By supporting the PHSSSP, the MCOs would take steps towards meeting their Healthcare Effectiveness Data and Information Set Measures (HEDIS). HEDIS Measures, developed and currently maintained by National Committee for Quality Assurance (NCQA), is a tool used by 90 percent of health plans in the United States to gauge performance in delivery of care and services. By linking the school-based testing to the performance of the third-party payers, billing the MCOs for screening services ended up benefiting them as well.

### Key Questions

1. What champions (internal or external) might you call on to generate buy-in for a third-party billing system?

## V. BILLING PROCESS-RELATIONSHIP WITH THIRD-PARTY PAYERS

### Credentialing

In order to submit a claim for reimbursement to a third-party payer, a provider must go through a process called "credentialing." This entails verifying a provider's professional qualifications and may include verification of academic background and other relevant training, state licensure, board certification, registration to practice health care in a certain field, DEA registration, Curriculum Vitae, and tax forms, among other things. This process may be done directly with the insurance provider, although in some areas there are alternatives designed to expedite the process and eliminate duplicative effort for various providers.

For example, the Council for Affordable Quality Healthcare's (CAQH) is a non-profit alliance of health plans that has developed a Universal Provider Datasource (UPD). The UPD has a single, uniform application that a provider can fill out. The form is then accepted by many private health care plans, hospitals, and managed care organizations. There are currently more than 600,000 providers registered and over 400 participating third-party payers across the United States. This kind of database streamlines the data collection process and minimizes administrative costs and time burdens associated with credentialing.

The Philadelphia Department of Public Health STD Control Program through the partnership with the Family Planning Council was able to gain access to the UPD in order to credential the provider under whom the screening services are billed.

### Contracting

While it is not required to have a contract between a provider and a third-party payer, doing so allows the provider to be considered "in- network." Being in-network impacts the rate of reimbursement.

The Family Planning Council had contracts with two of the three existing Medicaid payers when PHSSSP began billing them. The STD Control Program submitted claims to the third payer until June 2012, when the Family Planning Council contacted with that payer as well. Over the last year a fourth Medicaid managed care provider came onto the market and a fifth will start soon. The Family Planning Council is contracting with those new plans as well.

### Key Questions

1. Choosing whether or not to credential health care providers and whether or not to

develop a contract with third-party payers impacts your status as in-network or out of network provider which in turn impacts your rate of reimbursement, among other considerations. What would be the cost benefit to credentialing and or contracting for your clinic?

2. The Council for Affordable Quality Healthcare's Universal Provider Datasource CAQH is one resource that supports credentialing health care providers with third-party payers. What are the pros and cons of choosing to go this route for your clinic?

## VI. BILLING PROCESS-PATIENT FLOW

### Intake

The testing protocol includes gathering demographic information from clients and asking for consent to bill their insurer for reimbursement on the lab testing fees.

Every student participating in the program (whether he/she opts to be tested or not) receives a form to fill out requesting the following information (please see next page).

### Provider Encounter

The PHSSSP operates under a method of self-collected urine samples, so no provider sees the student directly. After completing the intake form, the student is given a brown paper bag with an empty specimen cup along with the form, enters a bathroom stall, provides a urine sample, and then deposits the closed brown paper bag in a collection bill. Students who do not wish to be tested can return an empty specimen cup in the brown paper bag. For added confidentiality, no one knows if the bag contains a specimen when it is deposited in the collection bin.

## VII. BILLING PROCESS- CLAIMS PROCESSING

If the student chooses to be tested and gives consent for the program to bill his/her health plan, he or she signs the back of the intake form and staff uses the information on the form to look the individual up on the Medicaid eligibility roster. During the 2011-2012 school year, 78 percent of students signed the back of the form, and testing for approximately one-third of those who did give consent to bill were successfully billed through a Medicaid managed care organization. In order to further ensure confidentiality, PHSSSP only submits claims for testing, and does not submit claims for treatment, as this would identify the student as having tested positive for an STD. The Philadelphia Department of Public Health STD Control Program assumes the cost for any treatments provided, underscoring the continued role of safety net discretionary monies.

Philadelphia Department of Public Health STD Control Program sends a list, using a secure FTP site, to the Family Planning Council identifying all of the students who have given consent to have claims submitted on their behalf. The Family Planning Council then checks them against the Medicaid electronic verification system and identifies who is enrolled under which Medicaid managed care plan. The Family Planning Council pays an annual fee to have access to the registries for public insurance (Medicaid and Medicare). The Council generates bills for students covered under two of the plans, and sends these in monthly batches to a clearinghouse that performs a final check on the claims to ensure there are no errors or potential for rejecting the claim. The clearinghouse then submits the two Medicaid managed care providers. Until June 2012, the Council was not able to submit claims to the third Medicaid MCO so a list of students covered under the third plan was sent back to the Philadelphia Department of Public Health STD Control Program and the Philadelphia Health Department billing department then submitted bills to that provider.

**FRONT ON THE FORM**

First Name_____ Last Name_____

Address_____ Zip_____

Telephone #_____

Race_____ Sex_____

Have you ever had sex?_____ Grade_____

Secret code [to be used when receiving test results]_____

Best way to contact you_____

Today's Date_____

School_____

**BACK OF THE FORM**

I understand that my testing and test results are confidential and will not be given to anyone else. By signing below, I agree to allow the Health Department to let my health choices health plan know that I was tested so that the cost of testing can be shared. TEST RESULTS WILL NOT BE SHARED. I understand that I can still be tested if I don't sign this form.

Printed Name_____

Signature_____

Date_____

### Follow Up on Claims

Once a claim has been submitted, if it is approved for payment by the third party-payer, a remittance is sent to the City of Philadelphia. The city has only one tax ID number, so when claims are submitted on behalf of PHSSSD, the funds go back to a central account. The program is responsible for tracking these funds and requesting them from the city.

A claim may be denied by a third-party payer for a variety of reasons. For example, a student may not actually have coverage on the date of service or there may be a discrepancy between the test date and the date on the claim. If a claim has been denied or is delayed, staff from the Philadelphia Department of Public Health STD Control Program will contact the third-party payer to follow up. In one instance, an entire month of claims went unpaid by one insurance provider that didn't have record of the first submission. The Philadelphia Department of Public Health STD Control Program staff member was then able to provide the necessary documentation and follow up to ensure that the payment was made.

#### Key Questions

1. Who else in your health department is billing third-party payers? Who might you connect with to learn more about how they developed their billing practice and for what services?

## VIII. PARTNERSHIPS, COLLABORATION AND LEVERAGING RESOURCES

The collaboration between the Family Planning Council and the Philadelphia Department of Public Health STD Control Program has been key to success in mobilizing and sustaining the third-party billing practice of the school-based screening program. The Family Planning Council has the knowledge and experience with third-party billing and it is through a partnership with the Council that the PHSSSP is able to bill for its services. The Council is a private, non-profit organization whose "mission is to ensure access to high quality, comprehensive, reproductive and related health and prevention services to primarily low-income individuals and families…." In fulfilling this mission, the Council provides financial and other administrative support to a wide range of organizations and programs.

Philadelphia Department of Public Health STD Control Program staff enters data into the disease control management system for all students who opted to be screened for Chlamydia and gonorrhea. The department's health records system is a DOS-based database that was designed specifically for the health department in 1991 and is currently being upgraded.

The Philadelphia Department of Public Health STD Control Program staff extracts data into a spreadsheet on those who have given permission to bill a third-party payer which is given to the Family Planning Council and entered into the EPIC electronic health records to generate a claim.

#### Key Questions

1. The family planning community has been successfully carrying out third-party billing practices for many years. What local partners might be a valuable resource to you as you learn more about developing and implementing a third-party billing practice?

## IX. STAFF AND PROVIDERS

There are several critical points of contact who contribute to a successful third-party billing practice for the PHSSSP. First, facilitators deliver the educational program and oversee the intake process when students fill out their forms with demographic info and consent to bill. A Philadelphia Department of Public Health STD Control Program staff member enters data, serves as a liaison to the point of contact at the Family Planning Council, and follows up with the third party payers when claims are denied or held up. The Family Planning Council also has a point person who is responsible for processing claims and tracking claims that have been rejected or delayed.

There is only one provider under whom the services are billed to third-party payers. The provider is a physician who works in the Philadelphia Department of Public Health STD clinic.

## X. MESSAGING TO CLIENTS

Billing third-party payers is not the primary focus of the Philadelphia High School Screening Program and most of the program's messaging focuses on the rationale for the screening availability and addresses procedural questions that arise from an off-site screening program. There is a letter sent to parents informing them about the screening program, along with a list of frequently asked questions.

The Program staff delivers a presentation to students informing them about the screening being offered to them. As part of this presentation, students are informed that this service is provided free of charge but that if they wish to help support the program, they may give consent to bill their third-party payer on their behalf. Students are not required to state whether or not they have Medicaid coverage as verification is part of the process.

## XI. CAPACITY BUILDING

The Philadelphia Department of Public Health STD Control Program staff developed the skills needed to bill third party payers through collaborations with internal and external partners. They were able to leverage the expertise of the Family Planning Council and the billing staff in the health department and learned about the various steps needed through these relationships and by implementing the program. The Family Planning Council was a particularly important resource for technical assistance as it has a long history of billing third-party payers and building capacity in third-party billing for family planning clinics in the region.

## XII. NEXT STEPS AND ASPIRATIONS

The Philadelphia Department of Public Health STD Control Program staff is pleased with the fact that they receive remittances on approximately 90 percent of the claims submitted and count this as a great success. These returns are the result of diligent follow up and the staff hopes that the results demonstrate the merits of such efforts. They hope to expand the numbers of students reached through the High School Screening Program.

NCSD
National Coalition of STD Directors
*Promoting Sexual Health Through STD Prevention*

## Philadelphia City and County, Pennsylvania - STD Data At-a-Glance

Chlamydia

- In 2010, Philadelphia, PA ranked 6th of all U.S. counties and independent cities for number of reported cases of Chlamydia, with 19,428 cases and an overall rate of 1,255.6 cases per 100,000 population.

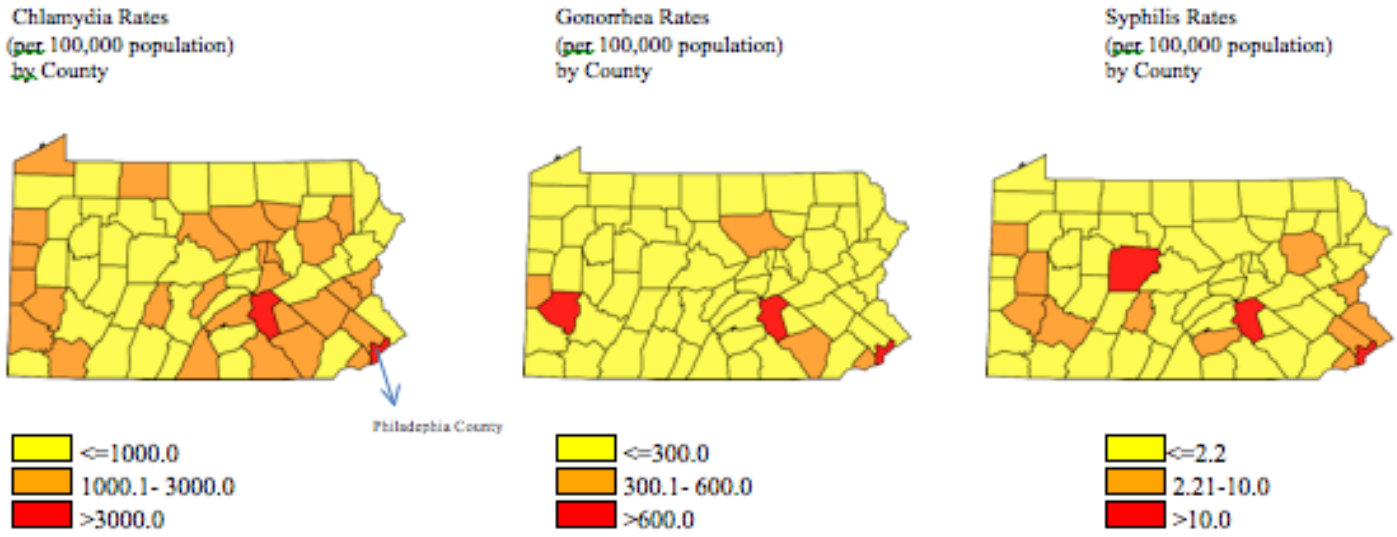
Gonorrhea

- In 2010, Philadelphia, PA ranked 4th of all U.S. counties and independent cities for number of reported cases of Gonorrhea, with 6,533 cases and an overall rate of 422.2 cases per 100,000 population.

Syphilis

- In 2010, Philadelphia, PA ranked 10th of all U.S. counties and independent cities for number of reported cases of Syphilis, with 238 cases and an overall rate of 15.4 cases per 100,000 population.

## Rates of Reportable STDs among Young People 15 - 24 Years of Age Pennsylvania, 2010




## Recent Trends

- Since 2008, Chlamydia rates have been steadily increasing among males and females in Philadelphia.
- In 2011, females 15-19 years old experienced the highest rates of Chlamydia of any group in Philadelphia.
- In 2011, the rate of syphilis for males was 5 times higher than for females, and approximately 75% of cases among males in Philadelphia were among men who have sex with men (MSM).
- In 2011, females 15-19 years old experienced the highest rates of Gonorrhea of any group in Philadelphia, followed closely by males 15-24 years old.

## Sources:

Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2010. Available at: http://www.cdc.gov/std/stats10/default.htm

Philadelphia Department of Public Health. STD Surveillance Summaries. Available at: https://hip.phila.gov/xv/Surveillance/STDSurveillance/tabid/126/Default.aspx


# Basics of Coding for Third-Party Billing

Billing a third-party payer for the services a client receives requires accurate and appropriate documentation both of the reason that a client is being seen by a health care provider and of the services or procedures provided.

The International Classification of Diseases (ICD) is a comprehensive list of codes that serve as the standard diagnostic tool to indicate disease, injury, symptoms, reasons for the encounter, and any factors influencing the client's health, whether new or existing. These codes are determined by the World Health Organization (WHO). ICD-9 codes are currently used in the United States and are called such because they represent the ninth iteration of this resource. While ICD-10 codes have been established, they have not yet been implemented in the United States, although the transition is forthcoming. On October 1, 2013, ICD-10 codes will replace ICD-9 codes as standard procedure. Any visits taking place on this date onward require ICD-10 coding. However, as any claims generated for visits prior to this date will have the ICD-9 coding, and processing those claims may take up to a year if there are any delays or challenges, it is important to know about both sets of codes as this transition will occur over the span of a year before being phased out entirely.

Current Procedural Terminology (CPT) codes refer to the specific services that may be performed during a client's visit. These are particularly important in a third-party billing setting as they determine the reimbursement amount to be received from the third-party payer. The American Medical Association convenes a panel of experts to maintain and update these codes annually.

There is a relationship between ICD-9 and CPT codes, and there must be a direct connection between the diagnosis (as demonstrated by the ICD-9 code) and the service provided (as demonstrated by the CPT code). It is critical that both administrative staff and health care providers understand how to code. While some clinics find it useful to have someone on staff who has certification in medical billing and coding, others finds that they are able to develop, implement, and maintain third-party billing practice with the support of external billing specialists through training and/or ongoing guidance.

There are codes covering every imaginable diagnosis and service, however, an STD clinic is likely to use a more defined set of codes based on the most common health complaint and services. It may then be helpful to develop an encounter form or superbill which lists

the most commonly used ICD-9 and CPT codes used in your setting so it can easily be filled out by the health care provider or clinical staff, based on the health care providers notes.

Below is the superbill developed by the Denver Metro Health Clinic to support its third-party billing practice. It represents the most commonly used diagnosis and service codes for a comprehensive sexual health clinic, including STD, HIV/AIDS, and family planning related services.

Following the superbill is a brief primer illustrating how the shift from ICD-9 to ICD-10 will impact coding. The primer highlights 15 common diagnoses, symptoms or reasons for being seen, listing the current ICD-9 coding along with the translation to the ICD-10 coding that will be used after October 1, 2013. It also includes notes describing how the new code is similar to or different from the old code, as well as documentation explaining relationships and other noteworthy characteristics. While learning how to assign codes requires more detailed training, this primer serves to introduce you to the current and forthcoming coding practice.

This brief overview to coding and sample superbill introduces some of the basic concepts around coding and demonstrates a tool used to support a successful third-party payer billing practice. If you would like to learn more about coding, you may also be interested in the following resources:

- The NIATx Third-party Billing Guide
- Georgia Department of Public Health: Public Health Billing Resource Manual

**DENVER HEALTH AND HOSPITALS**
**PUBLIC HEALTH SERVICES** **2012**

**STD Primary Care Clinic**

Patient Name
MR#_____
Account Number#_____
DOS:_____

**Change/Add PCP:_____**

**CARE PROVIDERS**

| | | | |
|---|---|---|---|
| | | | |
| | | | |

POSTED

**CIRCLE 4 DIGIT CODE FOR CLINIC VISIT AND CIRCLE 4 DIGIT CODE FOR EACH PROCEDURE PERFORMED**

**PREVENTIVE CLINIC VISITS**

| PREVENTIVE VISIT | New Patients | |
|---|---|---|
| | Charge | CPT |
| Age 12 - 17 yrs. | | 99384 |
| Age 18 - 39 yrs. | | 99385 |
| Age 40 - 64 yrs. | | 99386 |
| Age 65+ yrs. | | 99387 |

| PREVENTIVE VISIT | EST PATIENTS | |
|---|---|---|
| | Charge | CPT |
| Age 12 - 17 yrs. | | 99394 |
| Age 18 - 39 yrs. | | 99395 |
| Age 40 - 64 yrs. | | 99396 |
| Age 65+ yrs. | | 99397 |

| PROCEDURES/CONTRACEPTIVE | Charge | CPT | QTY |
|---|---|---|---|
| Insertion Contraceptive Capsule | | 11975 | |
| Removal Contraceptive Capsule | | 11976 | |
| Diaphragm Fitting | | 57170 | |
| IUD Insertion | | 58300 | |
| IUD Removal | | 58301 | |
| Insertion nonbiodeg deliver system | | 11981 | |
| removal of non biodeg deliver system | | 11982 | |
| removal & reinsertion of system | | 11983 | |

| PROCEDURES/LAB & PATH | Charge | CPT | QTY |
|---|---|---|---|
| Urinalysis, Dip & Micro | | 81003 | |
| Urinalysis, Non Auto w/o Mic | | 81002 | |
| CD4 Cell Count | | 86361 | |
| Quantiferon | | 86480 | |
| Test Syphilis, Qualtative | | 86592 | |
| HTLV I/II Confirmation-WBLOT | | 86689 | |
| AB, Herpes Simplex Type 1 | | 86695 | |
| AB, Herpes Simplex Type 2 | | 86696 | |
| Hepatitis B Surface AB | | 86317 | |
| Hepatitis C Antibody | | 86803 | |
| Neisseria Gonorrhea Culture | | 87077 | |
| Smear Primary Source, Gram | | 87205 | |
| Chlamydia Trach AMP (DHP) | | 87491 | |
| N Gonorrhea AMP (DPH) | | 87591 | |
| HPV (Amplified Probe Tech) | | 87621 | |
| Cytop, Monolayer w/int CX OR VG | | | |
| Cyto-Cytology Smear (PAP) | | 88141 | |
| Urine/Pregnancy test | | 81025 | |
| Serum/Pregnancy test | | 84703 | |
| Smear, West Mount w/Simple Stain | | 87210 | |

| Pharmacy Supplies | Charge | CPT | QTY |
|---|---|---|---|
| Depo Provera 1500MG/ML Injection | | J1055 | |
| IUD Mirena | | J7302 | |
| IUD Paragard | | J7300 | |
| Implanon Implant System | | J7307 | |
| Ortho Cyclen | | S4993 | |
| Emergency Contraception | | S4993 | |
| Pre-Natal Vitamins | | S0197 | |
| Condoms (male) | | A2667 | |
| Condoms (female) | | A2668 | |

**MEDICAL CLINIC VISITS**

| CLINIC VISIT | | EST | CPT | NEW | CPT |
|---|---|---|---|---|---|
| **Level 1** | Focused Visit | | 99201 | | 99201 |
| **Level 2** | Expanded Visit | | 99202 | | 99202 |
| **Level 3** | Detailed Visit | | 99203 | | 99203 |
| **Level 4** | Comprehensive | | 99204 | | 99204 |
| **Level 5** | Comprehensive | | 99205 | | 99205 |

| PREVENTIVE MEDICINE, INIDIVIDUAL COUNSELING | Charge | CPT |
|---|---|---|
| Individual Counseling 15 MIN | | 99401 |
| Individual Counseling 30 MIN | | 99402 |
| Individual Counseling 45 MIN | | 99403 |
| Individual Counseling 60 MIN | | 99404 |

| PROCEDURE/COMMON | Charge | CPT | QTY |
|---|---|---|---|
| S.Q. or I.M. | | 96372 | |
| Venipuncture | | 36415 | |
| ADMIN NON-SPEC VACCINE 1 VAC | | 90471 | |
| IMMUNIZATION ADMIN, EACH ADD | | 90472 | |
| LN2 to warts, molluscum (<14 lesions) | | 17110 | |
| Skin Tags (up to 15) | | 11200 | |
| Capillary Stick | | 36414 | |

| SMOKING/TOB CESSATION | Charge | CPT |
|---|---|---|
| Smoking Cessation > 3 - 10 min | | 99406 |
| Smoking Cessation > 10 min | | 99407 |

| PROCEDURE/FEMALE GENITAL SYSTEM | Charge | CPT | QTY |
|---|---|---|---|
| Vulvar Biopsy: One Lesion | | 56505 | |
| Vulvar Biopsy: Each Separate | | 56606 | |
| Vaginal Lesion Destruction/Simple | | 57061 | |
| Colposcopy-Vagina & Cervix | | 57420 | |
| ColposcopyVagina & Cervix w/biopsy | | 57421 | |
| Colposcopy-Cervix without Biopsy | | 57452 | |
| Colposcopy-Cervix with Biopsy | | 57454 | |
| Cryotherapy Cervix | | 57511 | |
| Destruction lesion/Vulvar-single or simple | | 56501 | |
| Destruction lesion/Vulvar-Multi or Complex | | 56515 | |

| PROCEDURE/MALE GENITAL SYSTEM | Charge | CPT | QTY |
|---|---|---|---|
| Destruction Lesion/Penis-Chemical | | 54050 | |
| Destruction Lesion/Penis -Cryo | | 54056 | |
| Destruction Anal Lesion - Cryosurgery | | 46916 | |
| Destruction Anal Lesion-Chemical | | 46900 | |

| | P | S | |
|---|---|---|---|
| **WELL WOMAN/GYN/ ANAL PAP** | | | |
| Female Pelvic exam with or w/o PAP | | | V72.31 |
| Breast Lump | | | 611.72 |
| Cervical CA screening (pap w/o pelvic) | | | V76.2 |
| ASCUS Pap | | | 795.01 |
| LGSIL | | | 795.03 |
| HPV for cervical cancer screen | | | V73.81 |
| **BEHAVIORAL/MENTAL HEALTH/SUBSTANCE ABUSE** | | | |
| Alcohol Depend. other/ unspecified | | | 303.90 |
| Cocaine Abuse, Episodic Use | | | 305.62 |
| Depression, not elsewhere classified | | | 311 |
| Depression-MAJOR-single/unspecified | | | 296.20 |
| General Counseling & Advice | | | V25.0 |
| Sexual Dysfunction (Psychosexual) | | | 302.70 |
| Substance Abuse Counseling | | | V65.42 |
| Substance Abuse, Other/Mixed/NOS | | | 305.90 |
| Tobacco Dependence/Abuse | | | 305.1 |
| **CARDIOVASCULAR** | | | |
| Elevated Blood Pressure - w/o dx HTN | | | 427.60 |
| **CONTRACEPTION** | | | |
| Birth Control Pill Management | | | V25.41 |
| Contraceptive Counseling & Advice | | | V25.09 |
| Contraceptive Surveillance, Other | | | V25.49 |
| Contraceptive Surveillance, Previously Prescribed | | | V25.4 |
| Contraceptive Surveillance, Subdermal | | | V25.43 |
| Contrceptive Surveillance, Unspecified | | | V25.40 |
| Counseling/Instruction Natural Family Planning | | | V25.04 |
| Emergency Contraceptive Counseling & Prescription | | | V25.03 |
| Initiation of Other Contraceptive Device | | | V25.02 |
| Insertion of implantable subdermal contraceptive | | | V25.5 |
| IUD insertion | | | V25.1 |
| IUD managemnt-chckng/reinsert/removal | | | V25.42 |
| IUD Removal | | | V25.12 |
| IUD Removal & Reinsertion | | | V25.13 |
| Existing IUD | | | V45.51 |
| Other Specified Contraceptive Management | | | V25.8 |
| Preconception Counseling | | | V26.49 |
| Prescription of Oral Contraceptives (initial) | | | V25.01 |
| Tampon Removal | | | 939.2 |
| Unspecified Contraceptive Management | | | V25.9 |
| **ENDOCRINE/METABOLIC** | | | |
| Obesity NOS (BMI < 40) | | | 278.00 |
| Obesity, Morbid (BMI > 40) | | | 278.01 |
| Overweight | | | 278.02 |

| | P | S | |
|---|---|---|---|
| Depo-Provera Mgmt, subsequent | | | V25.49 |
| DUB | | | 626.8 |
| Dysmenorrhea | | | 625.3 |
| Dyspareunia | | | 625.0 |
| Galactorrhea | | | 611.6 |
| Infertility | | | 628.9 |
| Irregular menstrual Cycles | | | 626.4 |
| Pelvic Inflammatory Disease, acute | | | 614.3 |
| Pelvic Pain, chronic | | | 625.9 |
| PMS/Premenstral tension NOS | | | 625.4 |
| Trichomonas Vaginitis | | | 131.9 |
| Trichomoniasis, NOS | | | 131.9 |
| Vulvovaginitis, NOS | | | 616.10 |
| Vaginitis/Vulvitis-Candida | | | 112.1 |
| **GENITOURINARY SYSTEM** | P | S | |
| Dysuria | | | 788.1 |
| Epididymitis/Orchitis | | | 604.90 |
| Exposure to STD | | | V01.89 |
| Prostatitis, acute | | | 601.0 |
| Urethritis | | | 597.80 |
| Urinary Frequency | | | 788.41 |
| Urinary retention | | | 788.20 |
| Urinary Tract Infection (lower) | | | 599.0 |
| **GASTROINTESTINAL** | P | S | |
| Abdominal Pain | | | 789.00 |
| Abnormal cytology of anal PAP | | | 796.7 |
| Nausea/vomiting | | | 787.01 |
| **INFECTIOUS & PARASITIC DISEASES** | P | S | |
| AIDS | | | 042 |
| Bacteremia | | | 790.7 |
| Balanitis | | | 607.1 |
| Candidiasis, oropharyngeal | | | 112.0 |
| Candidiasis, esophageal | | | 112.84 |
| Candidiasis, vulvovaginal | | | 112.1 |
| Chlamydia | | | 079.98 |
| Chlamydial trachomatis | | | 099.41 |
| Genital wart Condyloma | | | 098.15 |
| Gonococcal infection, acute | | | 098.0 |
| Gonorrhea, acute infection | | | 098.0 |
| Hepatitis C | | | 070.54 |
| Herpes, Genital- NOS | | | 054.10 |
| Herpetic Ulceration Uvlva | | | 054.12 |
| Herpes Vulvovaginitis | | | 054.12 |
| Herpes Penis | | | 054.13 |
| Herpes, Simplex, Oral | | | 054.2 |
| Herpes Zoster, w/o complications | | | 053.9 |
| HIV Infection (+), Asymptomatic | | | V08 |
| Syphilis | | | |
| *Syphilis – unspecified* | | | 097.9 |
| *Syphilis – primary* | | | 091.0 |
| *Syphilis – secondary* | | | 091.3 |
| *Syphilis – neurosyphilis* | | | 094.9 |
| *Syphilis – latent* | | | 097.1 |
| **NEUROLOGICAL** | P | S | |
| Migraine | | | 346.90 |

| | P | S | |
|---|---|---|---|
| Herpes Simplex | | | 054.9 |
| Herpes Zoster | | | 053.9 |
| Molluscum contagiosum | | | 078.0 |
| Pruritus | | | 698.9 |
| Psoriasis | | | 696.1 |
| Scabies | | | 133.0 |
| Sebaceous Cyst | | | 706.2 |
| Skin tags | | | 701.9 |
| Tinea, versicolor | | | 111.0 |
| Tinea Pedis | | | 110.4 |
| Tinea corporis | | | 110.5 |
| Ulcer, chronic | | | 707.9 |
| Urticaria | | | 708.9 |
| Viral Warts inc. genital | | | 078.10 |
| Wound Infection | | | 958.3 |
| **SYMPTOMS, ILL-DEFINED CONDITION** | P | S | |
| Allergic Reaction NOS | | | 995.3 |
| Fatigue/Malaise | | | 780.79 |
| High Risk Sexual Behavior | | | V69.2 |
| **PREGNANCY TESTS** | P | S | |
| Pregnancy Test Positive | | | V72.42 |
| Pregnancy Test Negative | | | V72.41 |
| Pregnancy Test Unconfirmed | | | V72.40 |
| **EXPOSURE TO:** | P | S | |
| Exposed to STI/STD | | | V01.6 |
| Exposed to HIV (or other virus) | | | V01.79 |
| **SCREENING (no sign/symptom)** | P | S | |
| STI | | | V74.5 |
| Chlamydia | | | V73.88 |
| HPV | | | V73.81 |
| HIV/Virus | | | V73.89 |
| Breast CA | | | V76.19 |
| **OTHER** | P | S | |
| Feared complaint, no problem | | | V65.5 |
| Observation; Condition not found | | | V71.89 |
| Worried Well | | | V65.5 |
| Noncompliance w/med treatment | | | V15.81 |
| General medical exam | | | V70.0 |
| General Med exam including GYN | | | V76.2 |

| ICD-9 Code | ICD-9 Description | ICD-9 to ICD-10 | Mapping Notes | ICD-10 Code & Description | ICD-10 Code & Description | ICD-10 Code & Description |
|---|---|---|---|---|---|---|
| **616.10** | Vaginitis and vulvovaginitis, unspecified | **4** | **Acuity of condition required** for accurate code selections. Selection of code must match language in the medical record - document acute or chronic. **Use additional code (B95-B97), to identify infectious agent.** | N76.0 Acute vaginitis | N76.1 Subacute and chronic vaginitis | N76.2 Acute vulvitis |
| **079.98** | Unspecified chlamydial infection | **1** | **A74 - Other diseases caused by chlamydiae Excludes1: sexually transmitted chlamydial diseases (A55-A56). If the Chlamydia is identified as STD-related, providers should use one of these codes instead of A74.9: A56-Other sexually transmitted chlamydial diseases, Includes: sexually transmitted diseases due to Chlamydia trachomatis; A56.0-Chlamydial infection of lower genitourinary tract; A56.00-Chlamydial infection of lower genitourinary tract, unspecified; A56.01-Chlamydial cystitis and urethritis; A56.02-Chlamydial vulvovaginitis; A56.09-Other chlamydial infection of lower genitourinary tract Chlamydial cervicitis; A56.1-Chlamydial infection of pelviperitoneum and other genitourinary organs; A56.11-Chlamydial female pelvic inflammatory disease; A56.19-Other chlamydial genitourinary infection Chlamydial epididymitis, Chlamydial orchitis; A56.2-Chlamydial infection of genitourinary tract, unspecified; A56.3-Chlamydial infection of anus and rectum; A56.4-Chlamydial infection of pharynx; A56.8-Sexually transmitted chlamydial infection of other sites.** | A74.9 Chlamydial infection, unspecified (Chlamydiosis NOS) | | |
| **098.0** | Gonococcal infection (acute) of lower genitourinary tract | **1** | **A54.00 is for unspecified location** within the genitorurinary tract without perirethral or accessory gland abscess; If Providers have more specific information on the location of the infection, they should consider selecting from these codes including A54.01-Gonococcal cystitis and urethritis, unspecified; A54.02-Gonococcal vulvovaginitis, unspecified; A54.03-Gonococcal cervicitis, unspecified; or A54.09-Other gonococcal infection of lower genitourinary tract. | A54.00 Gonococcal infection of lower genitourinary tract, unspecified | | |
| **091.0** | Genital syphilis (primary) | **1** | **A51.0-Primary genital syphilis (Syphilitic chancre NOS) is unspecified**; If providers have more specific information on the location of the disease, they should consider selecting the most specific code available. Other codes in this category include: A51.1-Primary anal syphilis, A51.2-Primary syphilis of other sites, and A51.5-Early syphilis, latent - Syphilis (acquired) without clinical manifestations, with positive serological reaction and negative spinal fluid test, less than two years after infection. Codes for Late syphilis are located in the A52 category and require specificity for syphilis-related conditions. | A51.0 Primary genital syphilis | | |
| **091.3** | Secondary syphilis of skin or mucous membranes | **2** | **Specificity of location required for accurate code selections. Selection of code must match language in the medical record - document specific type of syphilis as terminology is key to establishing relationship between conditions.** | A51.31 Condyloma latum | A51.32 Syphilitic alopecia | A51.39 Other secondary syphilis of skin (Syphilitic leukoderma, Syphilitic mucous patch) |
| **054.12** | Herpetic ulceration of vulva | **1** | A60.04 includes these: Herpesviral [herpes simplex] ulceration, Herpesviral [herpes simplex] vaginitis, Herpesviral [herpes simplex] vulvitis | A60.04 Herpesviral vulvovaginitis | | |
| **054.13** | Herpetic infection of penis | **1** | **No documentation or coding guideline changes.** | A60.01 Herpesviral infection of penis | | |

*Prepared by Christine Cox Associates.*

| ICD-9 Code | ICD-9 Description | ICD-9 to ICD-10 | Mapping Notes | ICD-10 Code & Description | ICD-10 Code & Description | ICD-10 Code & Description |
|---|---|---|---|---|---|---|
| **V08** | Asymptomatic human immunodeficiency virus [HIV] infection status | **1** | **Same coding guidelines in ICD10 as ICD9 for HIV and AIDS.** Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 (042 in ICD-9) in these cases. Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. | Z21 Asymptomatic human immunodeficiency virus [HIV] infection status | | |
| **V01.6** | Contact with or exposure to venereal diseases | **1** | **Generally the same coding guidelines as found in ICD9 V code Chapter.** This code excludes personal history of infectious and parasitic diseases and/or definitive carrier status or diagnosed current disease. | Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission | | |
| **599.0** | Urinary tract infection, site not specified | **1** | **Use additional code (B95-B97), to identify infectious agent.** N39.0 Excludes1: candidiasis of urinary tract (B37.4-), neonatal urinary tract infection (P39.3), urinary tract infection of specified site, such as: cystitis (N30.-), urethritis (N34.-). | N39.0 Urinary tract infection, site not specified | | |
| **614.3** | Acute parametritis and pelvic cellulitis | **1** | Use additional code (B95-B97), to identify infectious agent. Acuity must be documented. There are options for N73.0 acute, N73.1 chronic, and N73.2 unspecified (if no documentation of acute or chronic). | N73.0 Acute parametritis and pelvic cellulitis | | |
| **070.54** | Chronic hepatitis C without mention of hepatic coma | **1** | **No documentation or coding guideline changes.** Selection of code must match language in the medical record - document acute or chronic as there are different codes for Acute Hep C. | B18.2 Chronic viral hepatitis C | | |
| **112.84** | Candidal esophagitis | **1** | **No documentation or coding guideline changes.** | B37.81 Candidal esophagitis | | |
| **098.15** | Gonococcal cervicitis (acute). | **1** | **No documentation or coding guideline changes.** *See information for ICD9 098.0 for additional options in this category.* | A54.03 Gonococcal cervicitis, unspecified | | |
| **V73.88** | Special screening examination for other specified chlamydial diseases | **1** | Generally the same coding guidelines as found in ICD9 V code Chapter. Screening is the testing for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease. Excludes1: encounter for diagnostic examination-code to sign or symptom. | Z11.8 Encounter for screening for other infectious and parasitic diseases | | |

## TERMINOLOGY REFERENCE SHEET

**Charge master**: A comprehensive list of all services or supplies offered at a clinic or hospital including the procedure code and price.

**Claim**: A written bill for services, submitted by a patient or on behalf of a patient to the patient's health insurance carrier for payment, per the terms of the patient's health insurance plan.

**Claims Management Process**: Preparation, submission, and collection of health care claims.

**Clearinghouse**: A private company that serves to transmit and translate claim information from a health care provider or other billing entity to the third-party payers in the format required by the payer.

**Commercial insurance**: Also referred to as "private" insurance, a form of health insurance that is paid for by somebody other than the government. It may be paid for by the policy-holder and/or by the policyholder's employer.

**Contracting**: The process of developing an agreement between a health care provider and a third-party payer that allows the provider recognized as an in-network provider.

**Copayments**: The portion of the total amount billed for services that the patient is responsible for paying as determined by the terms of the patient's health insurance policy.

**Credentialing**: The process of establishing the qualifications of a health care provider with the health insurance provider.

**Electronic Health Records**: Computer-based systems for managing medical and/or billing information for patients.

**Encounter form**: Also referred to as a "superbill," this form is particular to each clinic and is designed to capture the diagnostic and procedural codes most frequently used in that clinic.

**Explanation of Benefits (EOB)**: A statement issued by a commercial insurance provider to the policyholder indicating medical services that were paid on behalf of the policyholder or any of the individuals covered on his/her policy.

**Health Information Technology**: Electronic environment or platform which enables the exchange or storage of health related information.

**HEDIS (Healthcare Effectiveness Data and Information Set)**: A set of measures used by more than 90 percent of health insurance providers to gauge their performance on dimensions of care and service.

**Medicaid Managed Care Organization**: An agency which supports delivery of Medicaid health benefits to clients, through an agreement with a state Medicaid agency.

**Medical home**: Also known as "patient centered medical home, this is a model for comprehensive health care delivery that facilitates treatment through a patient's primary care provider.

**Mid-level provider**: Health care providers, such as a Nurse Practitioner or Physician Assistant, who are licensed to diagnose and treat patients under the supervision of a physician.

**Paid claims**: A bill that has been submitted to a health insurance provider and payment has been made.

**Payer mix**: In a health care provider setting, this term refers to the sources of revenue, including commercial insurance, public insurance, and self-paying patients.

**Pending claims**: Bills for services rendered that have been submitted to a health insurance provider for payment, but have not yet been processed.

**Public insurance**: A form of health insurance that is paid for by the government, including Medicaid and Medicare.

**Remittance**: Payment from a health insurance provider to the health care provider who submitted the claim.

**State-based exchanges**: Mechanism to facilitate access to state regulated and standardized health insurance plans as mandated by the Patient Protection and Affordable Care Act.

**Superbill**: Also referred to as an "encounter form" this form is particular to each clinic captures the diagnostic and procedural codes most frequently used in that clinic.

**Third-party payer**: A public or private entity or program that is responsible for paying all or part of the expenses for medical care per the terms of the health insurance policy of the policyholder. A third-party payer neither receives nor administers medical care.

NCSD would like to thank our many supporters for their generous contributions including the Centers for Disease Control and Prevention, Family Planning Council, Good Works Group, Mary Wohlford Foundation, New Morning Foundation, and our member health departments across the country.

NCSD
National Coalition of STD Directors
*Promoting Sexual Health Through STD Prevention*

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