

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Maximizing Billing and Coding [Part 2]

1 December 2015

STEVE LUCKABAUGH: Good afternoon, and Happy World Aids Day. My name is Steve Luckabaugh. And I'd like to welcome you to the Maximizing Billing and Coding Part 2 webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC. The Partnerships for Care Project is a three-year multi-agency project funded by the Secretary's Minority Aids Initiative Fund and the Affordable Care Act.

The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment, in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. Our speaker today is Stacey Murphy. Stacey is a seasoned health care professional with more than 30 years of experience. She has held positions with the Veteran's Administration, Lebanon Hospital Center in the Bronx, and other private sector entities. She's an active member of the American Academy of Professional Coders and is very active with the NYMAC chapter in Queens, New York. She completed her undergraduate work in Health Administration at Saint Joseph's college in Brooklyn, New York and obtained an executive master's degree from Baruch College in public administration. She received her CPC coding designation in 1998 and is a designated ICD-10 trainer.

Stacey currently teaches health information management and medical coding courses at City University in New York, School of Professional Studies. And she teaches medical terminology and other health administration courses at Saint Joseph's College. Stacey's latest achievement is as a contributor to the upcoming American Health Information Management Association AHIMA white paper, State of Coding in Health Care Today. Please join me in welcoming Stacey Murphy.

STACEY MURPHY: Well, good afternoon, and thank you Stephen for such a warm welcome. So as Stephen mentioned, I currently teach medical coding and medical terminology courses at both my alma maters-- Saint Joseph's College as well as Baruch College. So let's get into our



webinar for today, the second installment of Maximizing Third Party Reimbursement Through Enhanced Medical Documentation and Coding. Right now we're just looking at the disclaimers. So let's go to the learning outcomes.

The webinar today will explain the importance of proper documentation in patient health records, identify and explain CPT codes and HCPCS codes, identify and explain the various CPT and HCPCS codes that are used to report HIV pre-testing, HIV counseling, HIV post-test, as well as a negative and positive results. And finally, to identify and explain commonly use modifiers when reporting the various CPT and HCPCS codes.

And before we get in to the presentation, we just wanted to start out with our first polling question. "What role do you play at your health care center or facility?" Are you A, clinical staff? An MD, NP, PA, RN? Are you the office manager, supervisor, front desk, or patient registrar? Are you the biller, coder, insurance-followup specialist, collections representative or, D, other? Please take a moment to participate in our quick poll.

OK, so today we have a large volume of individuals that are more in the billing and coding capacity versus our last webinar series where we had a mixture. So we have one more polling question before we get into our presentation. "Do you possess a familiarity with HCPCS codes?" Please select yes or no.

OK, so it's, again, almost 50-50. We have quite a few people that are familiar with HCPCS codes. And then we have some folks that are not so familiar with the HCPCS codes. So today for the folks who are not so familiar, hopefully you will learn a lot about the HCPCS coding system, especially as it relates to the AIDS and HIV care that you're providing your clinics and your office settings.

So this slide just gives you an overview of the commonly used acronyms. We're going to start out by talking about some documentation tips for our providers that are on the webinar. So in terms of your HIV testing documentation, some of the common elements that must be in the record for the first visit are the signed consent. And it varies from state to state.

Some states may require it and some states may not require it. So you should check with your insurance carriers and your local Medicaid agencies to see if this is one of those requirements. The test results should be notated in the patient's records and notation that the test results were communicated to the patient. And typically, with regards to the mode of communication, this should definitely be a face-to-face encounter.

The second visit consists of written justification for the rationale for the second or the subsequent tests such as any patient risk. And any additional counseling that the patient may or may not need should be documented in the patient's record. So your HIV pretest counseling without any testing written documentation should clearly state that counseling was provided. If the patient declines counseling, follow up care plan indicating the need for further testing and counseling. Those elements should all be documented in the patient's medical record.



So HIV counseling documentation-- the initial visit for confirmed results. So, again, the documentation and the patient's record should indicate the test results, any patient referrals for follow up medical care or supportive services, follow up to confirm any continuum of care, prevention risk factor reduction, counseling, and a follow up care plan, partner counseling and assistance, including any domestic violence screening if applicable. All of this should be documented in the patient's record for their initial visit for HIV counseling.

A medical provider and AIDS reporter-- now, so again, in terms of the state or you're jurisdiction, you should check to determine whether or not your local Medicaid state agency requires this because in some states, it's mandatory. And in some states, it may not be a mandatory requirement. So you should contact your local Medicaid agency for specific guidance.

Annual assessments should consist of prevention, risk factor reduction counseling, and a followup care plan. It should also consist of partner counseling and assistance to include any domestic violence screening. So, again, these are very important elements that must be documented in the record for your annual assessment.

In terms of the codes and the types of examples that we're going to look at today in the our webinar, please make sure you follow up with your state Medicaid agencies and all of your insurance plans that you participate with to find out whether or not they cover the rapid HIV test because I'm here in the New York New Jersey area, and it's covered. But in some of the webinars and coding seminars that I've done in other states, these are not considered services that are covered. So you should contact your local Medicaid and insurance plans to find out if these rapid HIV tests or the conventional screening tests are covered, depending on the state you're in.

So if you had the pleasure of attending the first webinar series, we discussed CPT codes. But we focus more on the preventives-- the preventive visit codes and the preventive counseling codes and the E&M codes. In this webinar series, we're going to look at the pathology and lab codes that are specific to the HIV test. So CPT codes-- we covered in our first series that there are six main sections. So we did evaluation and management in the first webinar series. And today, we're going to cover the pathology and laboratory section.

So in terms of your pathology and laboratory CPT codes, they're under the American Medical Association which was developed in 1966. The CPT codes are updated annually. And they are available for use in January. The CPT codes describe the various procedures and services that are performed to treat medical conditions. They're typically reported in the outpatient setting in physicians offices. But the CPT codes are also used in the outpatient hospitals setting.

So another code set that we will be discussing today in this webinar series are the HCPCS codes. The acronym HCPCS stands for Health Care Common Procedure Coding System. This code set was developed by CMS, the Centers for Medicare and Medicaid Services in 1983. The codes are

updated annually. And the HCPCS codes describe certain procedures and services that are used as a supplement to or in place of some of the CPT codes.

Now, in terms of the CPT versus HCPCS correlation, approximately 80% of the HCPCS codes cross map to some of the CPT codes. And for the most part, the HCPCS coding system was developed and implemented for the purposes of tracking statistics for the Medicare population. But a lot of the private insurance carriers, and even some state Medicaid agencies, also use some of the HCPCS codes. So you should check with your local Medicaid agency to see which HCPCS codes are applicable in your jurisdiction.

You should also check with your insurance carrier to find out which HCPCS codes are approved and reimbursed in your jurisdiction. Because even though the codes, even though the codes in your CPT books and your HCPCS and your ICD-9 books are all valid codes, you have to check with your insurance carrier to determine which codes are payable or reimbursable.

So now let's start to look at some of the codes. This slide here provides you an overview of the HIV antibody test codes. And so if you'll notice, this slide comprises of four codes that are the rapid HIV test. So your 86701 is a rapid test. The HIV 2 test is not commonly performed here. Or rather I should say, it's not a common service that is rendered here in the US. It's most common to the foreign countries because the HIV 2 is not considered one of those infections that is commonly diagnosed here in the US.

So for the purposes of the rapid test, the most commonly used codes are CPT 86701 or the HCPCS code G0435. Now, it's also important to note that the rapid tests are also referred to as point-of-care tests. And the reason why is because these are commonly performed in the doctor's office. And you get results real time. Whereas the other test codes that we're about to look at-- those require that the physician draw blood work and send the specimen to the lab for processing.

So the rapid test provide point-of-care screening and results. And this slide provides you an overview of the most common rapid tests that are used here in the United States. Typically, but not always, one test is payable every six months. So, again, I stress the importance of following up with your local Medicaid agencies as well as your insurance carriers because the reimbursement guidelines differ from insurance company as well as from state-to-state.

Now, if the physicians or the health care practitioners in your office decide, in lieu of a rapid HIV test, to draw blood, then in your office settings when a patient has an HIV test, the appropriate way to bill and get reimbursed for the service would also be to include the CPT code for venipuncture, which is 36415. Here are some additional HIV testing codes-- your HIV antigens. The antibody codes test for the presence of antibodies. And the antigen codes test for the presence of the HIV infection.

So, again, you have quite a few codes on this slide that are commonly used in the office setting as a rapid test. So you have G0432, your 87389. Those are commonly in the office settings. So

here are some additional codes. So these codes would not be utilized in a private doctor's office setting. These codes are typically used by the lab that you send the work out to be processed.

However, if you have a lab in your office that performs the specimens, that process the specimens, then the lab that is in your office would utilize these codes. So in short, these codes are not used by a physician because these are the codes that represent the actual processing of the spectrum. So let's take a couple minutes to see how much you recall about the HCPCS coding system in terms of what the acronym stands for.

So HCPCS stands for Hospital Care Procedure Coding System, Health Procedure Coding System, Health Care Common Procedure Coding System, or Hospital Clinic Procedure Coding System? So we have 65% has chosen choice C, and 35% were deceived and selected B. The correct answer is choice C-- Health Care Common Procedure Coding System.

So now let's take a couple of minutes to talk about modifiers. Modifiers are two-digit, sometimes numeric, sometimes alphanumeric, codes that indicate that a procedure or a service has been altered by a specific circumstance. But the code's definition has not changed. We have two types of modifiers. We have our CPT modifiers. And we have our HCPCS modifiers. Some of the modifiers impact reimbursement. And in terms of reporting requirements, modifiers are never reported alone.

Modifiers are never appended to ICD-10 codes. We will look at ICD-10 codes if you join us for webinar series 3, you will find out more information about the ICD-10 coding system. In terms of the modifiers, you should follow up with your local Medicaid agencies as well as all of the plans that you participate in because the use of modifiers varies from health plan to health plan. And it also varies from state to state.

So the two modifiers that are commonly used in reporting HIV tests are your modifiers 92 and your modifiers QW. Modifier 92, the description of this modifier is alternative laboratory platform testing. And so this slide just gives you an overview of what modifier 92 entails. It's a CLIA-waived test modifier that indicates that a lab test was performed in a doctor's office, that it's a single-use kit, that it's disposable, and that will not be reused on any other patients.

And in terms of the codes that are applicable with modifier 92 in the pathology and laboratory section, it's typically the first three codes that describe the rapid test-- your HIV test codes 86701 through 86703. All right, modifier 92 is typically not reported with any other code types. So, for example, if you attended webinar series 1, we spoke about E&M codes. So modifier 92 would never be appended to an E&M code service.

The modifier 92 is not reported with HCPCS codes. But, again, you should contact your local Medicaid agency for specific guidance because it varies from state to state. And my state, in New York/New Jersey, modifier 92 would not be appended to HCPCS codes. But in other states, the guidance is a little different. The guidance may advise that you append the 92 modifier to

the HCPCS codes. And just as a recap, your HCPCS codes for the purposes of the pathology and laboratory section begin with the letter G.

So modifier QW is another one of those CLIA modifiers. And the description of modifier QW is CLIA waived test. And so under the 1988 Clinical Laboratory Improvement Amendments Act, a laboratory provider must have a certificate of compliance or certificate of accreditation to perform a CLIA waived test. And so those CLIA waived tests basically include the tests that are designated as simple under the FDA rules and regulations.

And so in terms of its reporting requirements, the QW modifier can be appended to the 86701 through 86703. Those are your rapid tests as well as the eight 87389. Just like in the case of the modifier 92, this modifier is typically not reported with any other co-types. So, again, to reiterate the E&M CPT codes, your 99381, which are your preventive medicine codes or your sick-visit codes, which are your 99201 through 99205, you would not append the modifier QW to those codes.

The coding guidance indicates that if a combination of a waived and a non-CLIA waived test are performed, that you should not use the modifier QW. But, again, just as a takeaway, it's very important that you follow up with your local Medicaid state agencies for specific guidance because they may have alternative guidance that you should be following in terms of the appropriate use of your modifier.

So now let's look at some case studies. Hopefully, the case studies will guide you in the appropriate use of code selection as well as the appropriate use of the modifiers. So this is a 27-year-old patient that presents to the primary care physician's office concerned about recently having unprotected sex. And they request an HIV test. This particular patient didn't have their well visit for the year. So the doctor also did a well visit.

Now, for the purposes of this webinar series, we're only looking at the rapid HIV test code. So for the rapid HIV test code, you would select the 86701, and depending on your jurisdiction and the guidance from your insurance carrier, you would append a modifier 92 or you would append a modifier QW. And because the service was performed in the physician's office, the patient would get their results the same day because this is one of those rapid point-of-care tests.

The next slide just provides you with the rationale for the reason for the final choice code selection. So this is an established patient that came in for counseling and testing. And the HIV 1 CPT code 86701 was selected for this patient. And I apologize. This says HIV test 2. This should be 1. But that's just a minor oversight.

The modifiers that are applicable for this service are 92 or QW, depending on your jurisdiction. So, again, you would just follow up with your insurance carriers to find out what is the appropriate modifier in your state. So this is a similar scenario. And so, again, the same

outcome. This is a rapid HIV test with counseling. And hopefully, you will be able to join us for the upcoming webinar series three where we look closely at the ICD-10 diagnosis codes.

And so even though the CPT codes are the same in some of these scenarios, the diagnosis outcome that you select will be very different. So for the purposes of this scenario, the same CPT code 86701 and then based on your jurisdiction, you would select modifier 92 or modifier QW. The next slide just gives you the same rationale for the services that were performed in this particular case study.

So case study number 3 has a different set of codes. It's a 47-year-old patient that presents to their PCP concerned about unprotected sex. The physician counsels the patient, and then draws blood work, and sends the specimen to the lab for processing. So now in this particular scenario, we are addressing the pathologists. If this is a service that if you're reporting the service for your physicians, then you should be used in one of the E&M codes or the counseling code, depending on your jurisdiction.

And you would also assign CPT code 36415 for that routine blood work, because, remember, the scenario says that blood work was drawn. So the primary care physician would not use any of the test codes on this slide. So now, in terms of the scenario, we gave you this example where the lab work was on site. So once the physician drew the patient's blood work, the labs were sent downstairs for processing.

So if you go to the next slide, you'll see the rationale for the code selection for this particular scenario. So, again, this is not the PCP coding. This is now the pathologists services, or the pathology aspect of the service, where the specimens are sent to the pathology lab or downstairs on site, where it's located, for processing.

The next case study is sick confirmatory HIV testing. So using that same patient, a 47-year-old high-risk patient presents to their primary care physician's office for follow up of an inconclusive HIV test result. The PCP performs the confirmatory tests. And the patient was counselled for 15 minutes and was advised to return for their results in 15 days. So, again, this is another one of those scenarios that describes the pathology service, not the PCP.

For the PCP, the PCP would report one of the counseling codes. So, again, since the scenario says that there was counselling involved, counseling codes was covered in series one. So that would be the 99401 from the series one reimbursements webinar that we did about a week ago. And the next slide gives the rationale. So since the documentation states this is a confirmatory test, the pathologist would report 86689. And, again, you would check with your local Medicaid agency for any specific coding and billing instructions.

So we added this one in at the last minute. A medical assistant accidentally punctures their finger after drawing blood on an AIDS patient. The office manager completes the workplace injury forms. And the medical office assistant is treated by the physician in the office. The physician performs a detailed history, problem-focused exam, and the medical decision making

includes blood work, medication, and counsel the patient regarding transmission prevention. Blood work is sent to the lab for processing.

So if you'll notice for the physicians aspect, again, for the purposes of the testing side, this physician would report three 36415. And the lab reports the eight 87390 through 87539, depending on which type of service. So it's based upon the methodology performed. So since the scenario didn't really go into the details about the methodology, we just provided you the code ranges. So the important point for this particular scenario is the position service, which is drawing the blood work. So that would be your CPT 36415.

So, again, once we get to the series three of this four-part series, we will look at the diagnosis codes. And you'll see the various code types for all of the scenarios in this webinar series. So here's the rationale-- the encounter for accidental needle stick. This is a sick-visit encounter.

So in terms of the code type by the physician in the office that's examining the medical office assistant, they would select a 99201 through 99205. This is under the presumption that the medical office assistant has never been seen in that doctor's office. Maybe the medical office assistant is patient in their practice. And so in the event that they are a patient, then you would not use the 99201 or 99205. You would use one of the established patient visit codes, which are your 99212 through 99215.

And based upon the documentation from the previous slide deck, this is probably a level 2, level 3, depending on the extent of counseling the physician did with the medical office assistant. OK, so we have another polling question. "Point of care tests are reported by MD's, NP's, and PA's, not pathologists?" True or false? OK, we have an overwhelming number of participants that have voted true. We have 12% that are false.

And so the answer, unfortunately, is true. So I'm sorry for the 12% that voted false. But just as a recap, point of care tests are typically reported in the doctor's office. The patient gets their results real time. So these would not, in theory, would not be performed by a pathologist.

So let's talk about some coding tips. We just did a poll. So let's recap. The point of care rapid tests and preventive care, including counseling. So depending on which one of the rapid tests was performed, we determine which one of those rapid test codes you would select. So, again, in this webinar series, we've covered both CPT and HCPCS codes. So you would have to check with your local state Medicaid agencies and your insurance carriers to determine whether or not they want you report the CPT codes or whether or not they want you to report the HCPCS codes, because again, it varies from state to state.

With respect to reporting of the rapid test codes, always remember that you should include one of the E&M service codes or the counseling code which was covered in series 1. Point of care rapid tests including counseling without preventive care-- so this would be one of your counseling coded, depending on which state you're in, or one of the sick-visit E&M codes. So again, it's really important that you take the time to review all of your insurance contracts and



also follow up with the provider relations department if your insurance contracts do not explicitly state CPT codes so that they can provide you with the fee schedules or the summary or the list of the covered services. That's information that they should be able to provide for you if you are a participating provider.

In terms of this particular slide, point-of-tests tests without preventive care. So this would be one of the counseling codes 99401 through nine 99404. Or if your insurance carrier said that they don't cover counseling codes, then you would use one of the regular E&M digit codes, 99212 through 99215 if it's an established patient or 99201 through 99205 if it's a new patient.

The bottom slide talks about HIV tests performed by the pathologists. So if you are a pathologist, you have a lab in your doctor's facility, these would be the codes that would be reported by the pathologist. And we forgot to talk about modifiers in these last two slides. So, again, you have to remember append your modifiers. So if you're doing an E&M service with a rapid test, depending on your insurance carrier or your local Medicaid state agencies, you would be appending modifier 25 to the E&M service, which was covered in slide deck 1, series 1. And for your rapid test or for your HIV test code, you would be appending modifier 92 or modifier QW.

So that's what we were just talking about the modifiers. CPT 87389 is a combination of the HIV 1 and HIV 2 tests. So remember, here in the US we commonly performed the HIV 1 test. It's not really referred to as HIV 1 and HIV 2. But HIV 2 is a more advanced strain of HIV that is typically not found here in the US. But some patients come from other countries. And they are often diagnosed with that different strain of HIV or AIDS. And so these are the test codes that describe those various services.

If the lab specimen is performed and processed the same day, the coding instructions state to report CPT 87839. CPT 87839 is the HIV 2 quantification test. So, again, that's only if that's what you're testing for. If you're just doing the regular HIV test code, then you can could report 86701 for that particular service.

So the last couple of slides just gives you an overview of the resources that were used to put the webinar series together for you. These are the coding resources for all of the coders and billers that are on the call. It's very, very important that you have the current edition of your coding resources in your office. I did a coding in-service for a client. And they were still utilizing coding books from three years ago. And they were wondering why the claims were being denied.

So it's very important that each year when the code books are updated that you make a concerted effort to get updated coding resources. So now I'd like to turn it back over to Stephen.

STEVE LUCKABAUGH: OK, we have some time here at the end for questions if you happen to have any questions. OK, we have one. "Does the CPT code or modifier change for rapid blood HIV test versus oral HIV test?"

STACEY MURPHY: I'd have to double check that. I believe that is the same code. The oral rapid HIV test is the same. So this is the same code. 86701. No questions?

STEVE LUCKABAUGH: It's pretty quiet. OK, we have a follow up. "The modifier 92 would go on all of the oral tests since they are single use?"

STACEY MURPHY: Oh, I'm sorry, I had it on mute. Yes.

STEVE LUCKABAUGH: OK, we have another question. "Would I bill under medical codes for dental HIV testing?"

STACEY MURPHY: Dental HIV testing-- isn't that oral? That should be oral.

STEVE LUCKABAUGH: OK, if you'd like to clarify that question.

STACEY MURPHY: Can they elaborate the question?

STEVE LUCKABAUGH: I can unmute your microphone if you want to ask it. All right, it's from Tiffany Thompson. She says, "Yes, but currently there isn't a dental CDT code for HIV testing."

STACEY MURPHY: Interesting. I would recommend the rapid 86701. But before use it, you should follow up with the insurance carriers to find out what guidance they have. It's really a good resource to use because they provide you with the most appropriate and applicable information for your jurisdiction. So what may be applicable in my jurisdiction may not necessarily be applicable in yours.

STEVE LUCKABAUGH: OK, any other questions? We have a couple minutes here. I'm not seeing any more questions. With that, I think we'll wrap things up. I want to thank you for participating in today's webinar. And we hope that you're able to find the information provided useful as you continue your for P4C Project and ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar contained a lot of very detailed information. I know you're going to want to review it again. You're in luck. Today's webinar was recorded. Audio and video versions of the entire webinar, as well as the slides from today's webinar, will be made available on the P4C website within the next few weeks. Copies of all our prior P4C webinars are currently available on the website on the P4C resources materials page at p4chivtac.com.

You will need to log in to access materials. If you need login credentials, send an email to p4chivtac at mayatech.com. If you want to download the slides for today's webinar, you can do so through the handouts section on the GoToWebinar toolbar the next minute or so while we're here and also a reminder that part 3 of the series will be on Monday, December 14th, which is approximately two weeks at the same time at 3:00 PM Eastern time. Part 4 will be on Friday, December 18th, the same week as part 3, so three and four on the same week.

So be sure to register for the final two installments. Registration information will be sent out via the Listserv. So be on the lookout for that. So thank you again for participating in today's webinar and thank you once again Stacey for that excellent presentation. If you have any additional questions for the P4C Project or for Stacey, please email us at p4chivtac@mayatech.com. Take care everyone. And we'll see you next time.