Assessing Billing Practices for Routine HIV and HCV Tests in Philadelphia's Clinical Settings

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Background:

Screening for HIV and HCV in clinical settings has garnered support in the past several years through recommendations by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force, among others. Clinical settings cited billing, reimbursement, and systems integration among the challenges to implementing HIV screening programs; this was attributed to limited billing experience, as well as variation in reimbursement when claims were submitted to third-party payers. HCV testing program staff expressed similar concerns.

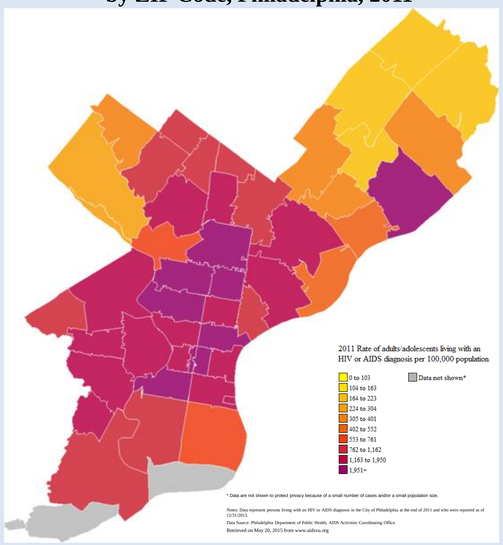
Objective:

To identify facilitating factors and barriers to billing and reimbursement for routine HIV and/or HCV tests performed in Philadelphia's clinical settings.

Methods:

The Pennsylvania/MidAtlantic AIDS Education and Training Center's (PA/MA AETC's) site at the Health Federation of Philadelphia assessed 11 clinical programs within seven healthcare organizations implementing routine HIV (n=9) and HCV (n=2) testing programs. At the time of assessment, all sites received funding to implement routine HIV and/or HCV programs, and were at varying stages of development and execution. Participating sites included inpatient (n=2), emergency department (ED) (n=2), and ambulatory care settings (n=7). PA/MA AETC developed and distributed a 22-question assessment addressing billing practices, reimbursement models, and general programmatic information. Individualized technical assistance was provided to increase questionnaire completion rates.

Rates of Persons Living with an HIV or AIDS Diagnosis, by ZIP Code, Philadelphia, 2011



Results:

All participating sites had existing revenue cycle management infrastructures, third-party payer contracts, and clinical billing experience. Billing models differed based on the location of HIV and/or HCV test completion; both clinical sites and laboratories generated claims and accepted remittance for services completed.

Claims were consistently submitted to third-party payers for HIV and/or HCV tests in 100% of inpatient sites, 50% of EDs, and 83% of ambulatory care sites. Limited billing was associated with rapid/point-of-care (POC) HIV tests, used by 27% of sites. All HCV tests were ordered through the laboratory.

Facilitating Factors and Barriers to Billing

Facilitating Factors:	Challenges/Barriers:
➢ Laboratory-based tests	➢ Rapid/POC tests
➢ Integrated clinical workflow	➢ Non-integrated workflow
➢ Electronic health records	➢ Unestablished billing processes
	➢ Funding restrictions

Reimbursement discrepancies were attributed to differing third-party payer contract stipulations and setting of test completion. Inpatient and ED financial departments received bundled, encounter-based reimbursement from all payers, regardless of clinical settings or laboratories completing HIV and/or HCV tests. The reimbursement rate in inpatient and ED settings differed by patients' diagnoses and clinical complexity; completion of HIV testing and CPT/HCPCS codes did not influence remittance amount or denial of claims.

Ambulatory sites primarily received bundled, encounter-based payment, including rapid/POC HIV test costs; select payers permitted fee-for-service reimbursement, equaling 15% of billed tests in one setting. Claims were most frequently denied due to third-party payer contract limitations or inclusion of rapid/POC HIV tests in the capitation rate. Ambulatory sites ordering laboratory-based HIV and/or HCV tests reported 99% reimbursement to laboratories; healthcare settings received bills from laboratories for unpaid tests. All setting types reported fewer denials and less departmental budget expenditures for laboratory-based tests.

Conclusions:

Laboratory-based testing is economically sound across sites due to clinical integration, utilization of electronic data interchange processes, and third-party payer contract stipulations. Sites that integrated HIV and/or HCV testing into their existing healthcare systems and infrastructure were more likely to report consistent charge capture and claims submission to third-party payers. Success is attributed to use of: 1) primary documentation and coding procedures, not alternative measures that are often used in parallel rapid/POC HIV testing programs; 2) automated processes of charge capture and coding with electronic health records; 3) electronic data interchanges for communication with third-party payers; 4) electronic ordering systems for laboratory-based tests. These strategies permit fewer opportunities for error, increasing billing rates. Laboratory-based HIV and/or HCV testing and systems integration requires fewer budgetary resources from clinical sites than rapid/POC testing, such as dedicated testers' salaries and test kits, and alterations in workflow.

Third-party payer "coverage" of testing does not guarantee fee-for-service payment or net revenue by clinical sites, as costs for laboratory tests are reimbursed to the laboratory and rapid/POC tests may be bundled in capitated payments. Reportedly, laboratory-based HIV tests costs less to process when compared to rapid/POC, and also limit departmental budgetary expenditures, such as staff time and supplies. Sites included in the assessment exclusively utilized laboratory-based HCV tests, but conclusions may be generalizable due to barriers and resource requirements affiliated with rapid/POC tests.

Patient uptake, payer mix, percentage of uninsured patients, and clinical resources must be considered when selecting testing models. Clinical, administrative, and financial staff should perform internal assessments for programmatic decision making and improvement. Stakeholders should consider the total costs of service provision and utilize the most cost-effective models for sustainable programs.

Subset of Assessment Questions

Billing:

1. Does your facility currently bill for health care services? Does this include HIV [and/or HCV] tests?
2. What is the payer mix for your patient population?
3. What HIV [and/or HCV] testing/service codes are used for screening and confirmatory tests?

Reimbursement:

1. What percent of patient visits are reimbursed?
2. Have you received denials? What reasons were indicated?
3. Are procedures in place if claims are denied?