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Third-Party Billing at the Oregon State Public Health Laboratory

Lessons from the Field

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Cardea serves as the STD-related Reproductive Health Training & Technical Assistance Center (STDRHTTAC) for U.S. Public Health Service Regions VI, IX and X. Cardea has developed this case study as part of a resource portfolio to support public health programs with third-party billing for sexually transmitted disease (STD) and other related services. Along with this and other case studies, the portfolio will include:

- Webinars and other resource materials
- An online learning community to facilitate peer learning
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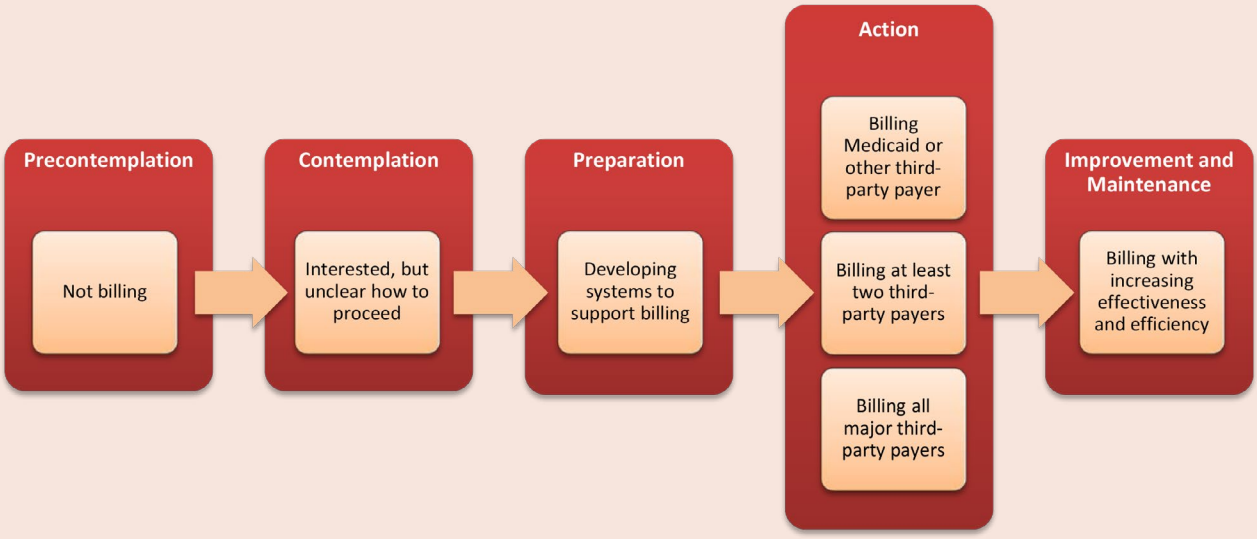
INTRODUCTION

Public health systems, including state and local STD programs and public health laboratories, are adapting to the changing health care environment. While these programs have historically relied on public funding to support the provision of free and low-cost health care services, funding has changed in recent years. With the impact of the Patient Protection and Affordable Care Act (ACA), programs are looking to Medicaid and other third-party billing to sustain services.

Public health programs seeking to bill Medicaid and other third-party payers for STD-related services face unique challenges. Policy and systems barriers, resource and capacity limitations, varying levels of leadership and staff buy-in, and concerns about billing for public health services often pose obstacles to implementation of billing in a public health setting. Case studies offer an opportunity to highlight the experiences of public health programs that have faced these and other challenges.

Cardea—Stages of Change Billing Continuum

Implementation of Medicaid and other third-party billing is one of many changes facing public health programs as they adapt to a changing health care environment. Developed by Drs. James Prochaska and Carlo DiClemente, the Transtheoretical Model (TTM) of behavior change, otherwise known as the Stages of Change, can be adapted to identify benchmarks of organizational capacity building for third-party billing. TTM describes the change process along a continuum of five stages: precontemplation, contemplation, preparation, action, and improvement/maintenance.



In the action stage, organizations may take one of three pathways: 1) billing a single payer, 2) billing at least two payers or 3) billing all major payers. Organizations that begin billing only one or two payers may need to return to the preparation stage as they modify systems.

CASE STUDY: OREGON STATE PUBLIC HEALTH LABORATORY

Oregon Program Partners

Oregon State Public Health Laboratory (OSPHL)—state public health laboratory; supports state and local infectious disease control efforts and assures the quality of testing in clinical and environmental laboratories;[1] and provides safety net chlamydia (CT) and gonorrhea (GC) testing services in collaboration with OSTDP and ORHP.

Oregon Sexually Transmitted Disease Program (OSTDP)—state STD program; works to prevent and control sexually transmitted infections by supporting screening, treatment and referral of exposed sex partners for evaluation and treatment, and emphasizes primary prevention through education and outreach;[2] and manages the federally funded STD service delivery grants, collaborating with OSPHL and ORHP to provide safety net CT/GC screening and treatment.

Oregon Reproductive Health Program (ORHP)—state family planning program; develops programs and recommends policies that prevent unintended pregnancy and associated problems and ensures that education and services addressing voluntary and effective family planning methods are available to all Oregonians;[3] and collaborates with OSPHL and OSTDP to provide CT/GC screening to high-risk female clients in family planning clinics.

Infertility Prevention Project (IPP)—a national initiative supported by the Centers for Disease Control and Prevention, Division of STD Prevention, in collaboration with the Office of Population Affairs, that ended in June 2012. IPP provided CT and GC screening and treatment services for low-income, sexually active women attending family planning, STD, and other clinics. Each regional IPP was a collaborative effort among representatives from state family planning and STD programs, public health laboratories and other key stakeholders.[4]

Oregon Health Plan (OHP): state-administered Medicaid program; provides health care coverage to low-income Oregonians through programs administered by DMAP; services are delivered locally to OHP clients through Coordinated Care Organizations (CCOs).[5]

Division of Medical Assistance Programs (DMAP)—oversees the budget, policies and systems of the Oregon Health Plan (OHP), Oregon's Medicaid program; provides daily service to OHP clients, prospective clients, community partners, contracted health plans and providers; and contracts with CCOs to deliver services locally.[6]

Oregon Contraceptive Care (CCare)—state Medicaid family planning waiver; covers specified reproductive health services under a fee-for-service model for Oregonians not enrolled in OHP with incomes at or below 250% of the federal poverty level; CCare claims reimbursement is issued monthly by ORHP.[3]

Additional acronyms and billing terms are included in the glossary at the end of this document.

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1 http://public.health.oregon.gov/PHD/Directory/pages/program.aspx?pid=6
2 http://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=41
3 http://public.health.oregon.gov/healthypeoplefamilies/reproductivesexualhealth/Resources/Documents/FP_Program_Manual/eManual.pdf
4 http://www.cardeaservices.org/ourwork/projects/infertility-prevention-project
5 http://www.oregon.gov/oha/healthplan/Pages/index.aspx
6 http://bluebook.state.or.us/state/executive/Offc_Medical_Assistance/medical_assist_home.htm

Considering a New Strategy

In 2009, OSPHL experienced a budget gap, due to the increased cost of new CT/GC test technologies and no corresponding increase in federal or state funds for testing. ORHP was billing CCare, the state Medicaid family planning waiver program, for eligible services and suggested that OSPHL pursue billing eligible tests to OHP, the state Medicaid program, to supplement existing funds.

OSPHL considered benefits and costs of billing Medicaid for CT/GC testing. A significant percentage of OSPHL's CT/GC testing volume was eligible for Medicaid billing. Without a billing system in place, OSPHL was potentially missing a valuable opportunity for additional revenue. Billing Medicaid for these tests would also reduce OSPHL's dependence on federal and state funds. OSTDP, the state STD program, supported OSPHL's intention to bill Medicaid. Realizing the potential to improve sustainability of public health laboratory services in Oregon, OSPHL quickly decided to take the first steps toward implementing third-party billing.

OSPHL felt that implementing a process to bill Medicaid only would yield a comparable number of billable tests and pose fewer challenges than billing multiple payers under separate contracts. OSPHL also saw the potential to build on an existing contract in which ORHP was billing CCare through Ahlers and Associates (Ahlers), an external billing agency. As part of the existing agreement, Ahlers screened submitted claims for Medicaid eligibility prior to submission, as visits eligible for reimbursement through Medicaid were ineligible for reimbursement through CCare. In addition, OSPHL had a relationship with Ahlers through the Region X IPP. OSPHL was sending IPP information to Ahlers and, more recently, electronically transmitting some information to facilitate data entry. OSPHL strategized that amending ORHP's existing contract to include billing for all Medicaid clients receiving OSPHL testing services would be more efficient than setting up new systems to bill private payers.

Lessons Learned—Precontemplation/Contemplation

- Consider billing Medicaid and other third-party payers to diversify revenue and provide sustainability for programs
- Weigh the advantages and disadvantages of 'starting small" vs. a more broad-based approach to billing implementation, including factors such as internal capacity; payer mix of your client population; and existing systems, resources and relationships

Getting Started

Contracting & Enrollment

OSPHL's first step was to work with ORHP and Ahlers to amend their existing contract. Contract amendments applied only to tests submitted with the Region X IPP lab slip, since tests submitted with OSPHL's standard virology form lacked the necessary fields for billing documentation. The amended contract included:

- Matching all submitted tests to identify client eligibility for Medicaid;
- Matching all submitted tests to identify client eligibility for CCare;
- Screening all submitted tests for agreement with IPP selective screening criteria; and
- Billing DMAP for eligible tests.

After executing the contract in early 2010, OSPHL's Client Services Coordinator was a key point person in driving billing implementation, establishing the lab's ability to bill DMAP. OSPHL had a National Provider Identifier (NPI) number and was able to easily obtain a Medicaid Provider Number, but learned in April 2011 that additional paperwork was required to begin billing. DMAP required a Trading Partner Agreement (TPA) with each provider to submit claims via the state's electronic data system. The

TPA also required the certification of any external billing agency. OSPHL found the TPA easy to complete, requiring only the Federal Tax Identification Number, NPI number, and signatures from both OSPHL and Ahlers, along with OSPHL's Medicaid Provider Number and Healthcare Provider Taxonomy Code.

Data Transfer & Claims Submission

While OSPHL enrolled as a Medicaid provider and amended an existing billing agency contract with relative ease, it faced a greater challenge with implementing a system for electronically transferring data to Ahlers and DMAP.

From September 2010 to August 2011, OSPHL worked diligently with Ahlers to ensure the correct transfer of all necessary data fields for third-party billing. The process began with Ahlers sending electronic transmission file formats to the OSPHL information technology (IT) staff, who used these layouts to create a test submission file. As file submission testing continued, OSPHL modified procedures, including ensuring that all records had required fields such as patient name and ICD-9 code. IT staff from OSPHL and Ahlers worked to add the necessary fields, negotiating field names and formats for compatibility across their respective systems. To protect patient confidentiality, identifiable fields such as patient name were transmitted for billing purposes and then removed from data reports.

After OSPHL and Ahlers coordinated their respective systems, they prepared to submit claims to DMAP's Electronic Data Interchange (EDI) unit to solicit feedback on test claims submissions. Ahlers submitted its first test file to EDI in March 2011, and the submission was rejected. OSPHL and Ahlers then worked with EDI to make corrections. By August 2011, OSPHL and Ahlers had invested a combined 150 hours for electronic systems programming and submissions testing and were ready to begin submitting claims.

Cost Estimation & Fee Setting

In March 2010, a program change allowed laboratory test costs to be unbundled from visit reimbursement costs for Medicaid billing. This change allowed OSPHL to bill Medicaid directly; the earlier bundling of costs restricted OSPHL to billing the clinical service provider who submitted the test and then sought Medicaid reimbursement.

Prior to implementing a third-party billing process, OSPHL sought to determine the cost of the combined CT/GC test, basing its analysis on the cost of testing specimens through pooling. OSPHL estimated a cost of $13.55/test, including the cost of labor and reagents and excluding administrative overhead, courier service and maintenance costs. If these additional expenses were included, the cost would have been $15-16/test. OSPHL noted that determining the true cost of testing is difficult for a public health laboratory.

Despite the acknowledged limitations, the fee for a combined CT/GC test was set at $13.55.

Lessons Learned—Preparation

- Leverage existing relationships—formal or informal—and resources to expedite the establishment of third-party billing
- Recognize that setting up billing systems with a new payer is challenging, and that maintaining a billing system will likely require less time and resources than initiating a new system
- Assign a point person to take the lead on billing implementation
- Establish a relationship with one or more contacts at the state Medicaid program or other third-party payers, if applicable
- Connect with other programs that support your program's billing operation (e.g., IT, procurement)
- Be as precise as possible in estimating costs, including labor, reagents, administrative overhead, courier services, maintenance, etc., as well as the estimated cost of billing recovery

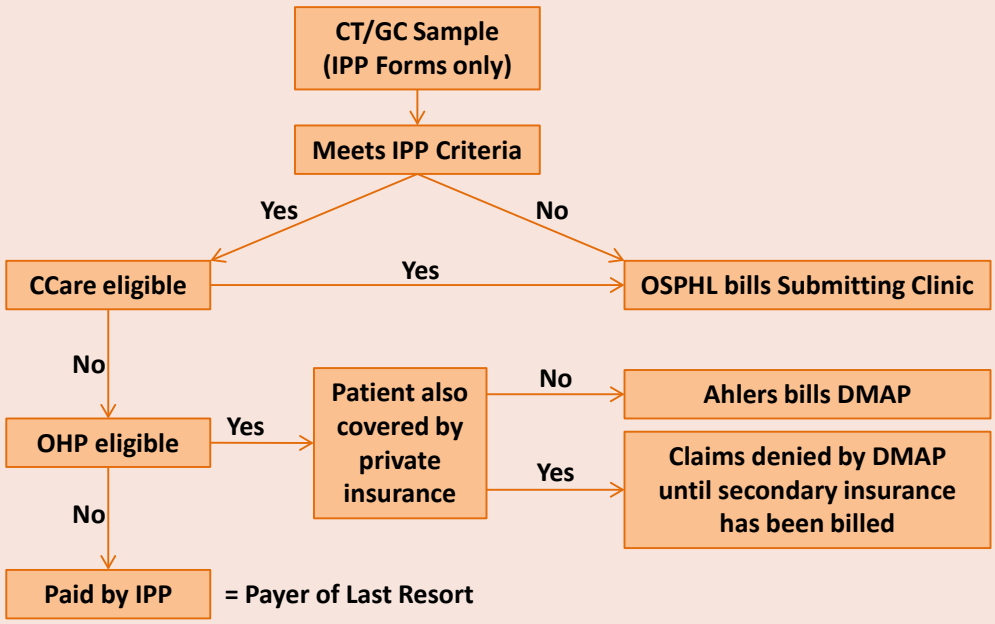
Billing Process Implementation

Insurance Eligibility Verification

OSPHL sends Ahlers an electronic file, including data on all CT/GC specimens submitted to the laboratory using the Region X IPP lab slip. Specimens submitted using this lab slip vary in eligibility for coverage through the state family planning program, Medicaid and private payers. Lab slip records are screened by Ahlers for each type of program insurance eligibility.

Ahlers reviews submitted test data for eligibility for IPP, CCare and Medicaid. IPP and CCare eligibility are determined based on program criteria. Medicaid eligibility is verified through OHP's Provider Web Portal. For tests that meet IPP criteria and are eligible for CCare, OSPHL bills the submitting agency/clinic, which seeks reimbursement through CCare. Those that are not CCare eligible, but are eligible for Medicaid are billed to DMAP, if the patient was not covered by private insurance. Those that are not CCare or Medicaid eligible are paid by IPP as the payer of last resort. For tests that do not meet IPP criteria, OSPHL bills the submitting agency/clinic.

Oregon State Public Health Laboratory Billing for Chlamydia/Gonorrhea Testing (2011-2012)



Claims Submission

Laboratory claims submitted to DMAP require both CPT and ICD-9 codes. OSPHL revised its systems to include this documentation in its data submissions to Ahlers. Once these initial adjustments were made, coding did not present a challenge. OSPHL uses a CPT code for the combined CT/GC test (87801 plus a family planning modifier). OSPHL relies on the submitting agency/clinic to include correct ICD-9 codes with submitted tests.

Each claim includes the established test fee of $13.55 and the NPI number of the ordering clinician at the submitting clinic. OSPHL learned through early test claims that DMAP rules require the NPI number of the ordering provider vs. the NPI number of an agency/clinic.

Denials Management & Collections

While OSPHL lacks the resources to follow up on rejected claims, the Client Services Coordinator would frequently reconcile Medicaid and Ahlers reports to determine which tests were billed and reimbursed. After adapting billing processes as a result of DMAP feedback during the initial months of implementation, OSPHL's claim rejection rate fell from 20% to 10%, eventually falling nearly to 0%. Virtually all claims for OHP eligible tests submitted by OSPHL to DMAP are approved.

When OSPHL fully implemented billing in late 2011, DMAP granted permission to back-bill the previous 12 months of testing. About 5,000 tests from the previous year were Medicaid eligible. Of these, approximately 80% were approved by DMAP, and OSPHL collected $70,000 from this retrospective billing process.

In 2012, the first full year of billing, OSPHL successfully billed an average of 600 specimens per month, totaling approximately $8,000/month in reimbursement payments. Medicaid payments are deposited into a dedicated OSPHL account for CT/GC testing services. DMAP sends physical checks directly to the Receiving Office, and the Receiving Office then sends OSPHL a copy of each check and a copy of the remittance advice.

Lessons Learned—Action

- Use the CPT code for combined CT/GC tests vs. individual test codes
- Include the NPI number for the provider who ordered the test vs. the agency/clinic that submitted the test
- Consider both general experience with Medicaid billing and experience with organizations or programs similar to yours, when contracting with any agency for third-party billing
- Establish a mechanism, when possible, through which reimbursement dollars can be deposited directly into your program's account, rather than into the state or local general fund

Process Improvements & New Challenges

Program Expansion

Based on its success to date, OSPHL plans to expand the number of tests submitted to Ahlers for eligibility screening and billing. Currently, Ahlers only processes tests submitted to OSPHL using the Region X IPP lab slip. As outlined earlier, OSPHL also receives CT/GC tests on a standard virology form and hopes to amend Ahlers' contract to include eligibility screening and billing for these additional tests.

OSPHL is also interested in expanding billing beyond CT/GC testing to include molecular testing for norovirus and other respiratory agents, tuberculosis and hepatitis.

Staff Capacity

OSPHL noted that a successful billing operation requires dedicated staff to spearhead the effort. OSPHL's Client Services Coordinator served as the point person for preparing, implementing and maintaining the Medicaid billing process. After that individual retired, OSPHL's Business Manager planned to assume some billing-related responsibilities, including monitoring billing statements,

following up as needed with Ahlers and DMAP and pursuing contracts with other third-party payers. Unfortunately, the Business Manager was asked at that time to split time between OSPHL and a second state program, significantly reducing that individual's availability to perform these functions. Without a dedicated staff member to lead billing operations, OSPHL's efforts to expand billing slowed down.

Legislative & Policy Considerations

Current Oregon legislation and policies impact OSPHL CT/GC billing. Modifying two current state rules could enhance OSPHL reimbursements: 1) allowing OSPHL to charge for services beyond those currently listed in Oregon Administrative Rules and 2) permitting an increase in the reimbursement rate for CT/GC testing services. Any increase in the $13.55/test Medicaid reimbursement rate requires a rule change, approved by the Department of Administrative Services for implementation and by the Oregon State Legislature for its continuation. OSPHL's goal is to link the test cost to the Medicaid fee-for-service schedule, allowing the reimbursement rate to adjust automatically as that fee schedule changes. The change in reimbursement would be significant. If the price were tied to the current Medicaid fee-for-service schedule, OSPHL's reimbursement rate would increase from $13.55 to $67.54/test. The additional funds would cover the true cost of the test for OSPHL and enable it to support testing for patients who are uninsured.

To bill other third-party payers, OSPHL would likely need to request an exception to current policy that requires billing to be channeled through the state Department of Administrative Services, Procurement Services. Medicaid billing is excluded from this policy. All other billable tests are sent to Procurement Services, which generates a bill to send to the submitting agency/clinic. If OSPHL is required to channel tests billable to other third-party payers through Procurement Services, the process may be difficult for OSPHL to manage efficiently and effectively.

Coordinated Care Organizations (CCOs) and the Future of CT/GC Billing

With Oregon's implementation of ACA, OSPHL faces a changing landscape. Beginning in September 2012, nearly all Medicaid clients were moved from OHP into Coordinated Care Organizations (CCOs). OSPHL has attempted to continue billing DMAP for Medicaid eligible tests, but DMAP will no longer reimburse these claims directly, since reimbursement is now channeled through the CCOs in the form of the global capitation payments that CCOs are expected to use to reimburse providers.

While state Medicaid rules do not require a formal agreement between OSPHL and the CCOs, the latter will likely require a contract prior to the reimbursement of claims. Specific contract requirements will vary across CCOs.

As a public health lab, OSPHL may face unique challenges in attempting to contract with CCOs. CCOs may choose to contract with private labs that can provide comprehensive services, rather than with OSPHL or other labs that are only billing for selected services. Private labs are actively marketing themselves to CCOs, resulting in increased competition for OSPHL.

While OSPHL has yet to execute formal contracts, it has developed informal relationships with three CCOs serving one-third of the counties from which the laboratory receives specimens. OSPHL is working to establish relationships with the remaining CCOs. One-third of the CCOs in Oregon use the same fiduciary intermediary, so OSPHL should be able to bill these CCOs through a single contract with this intermediary organization. OSPHL staff noted that this progress has made the CCO landscape look somewhat less challenging, although developing billing relationships will still require significant effort.

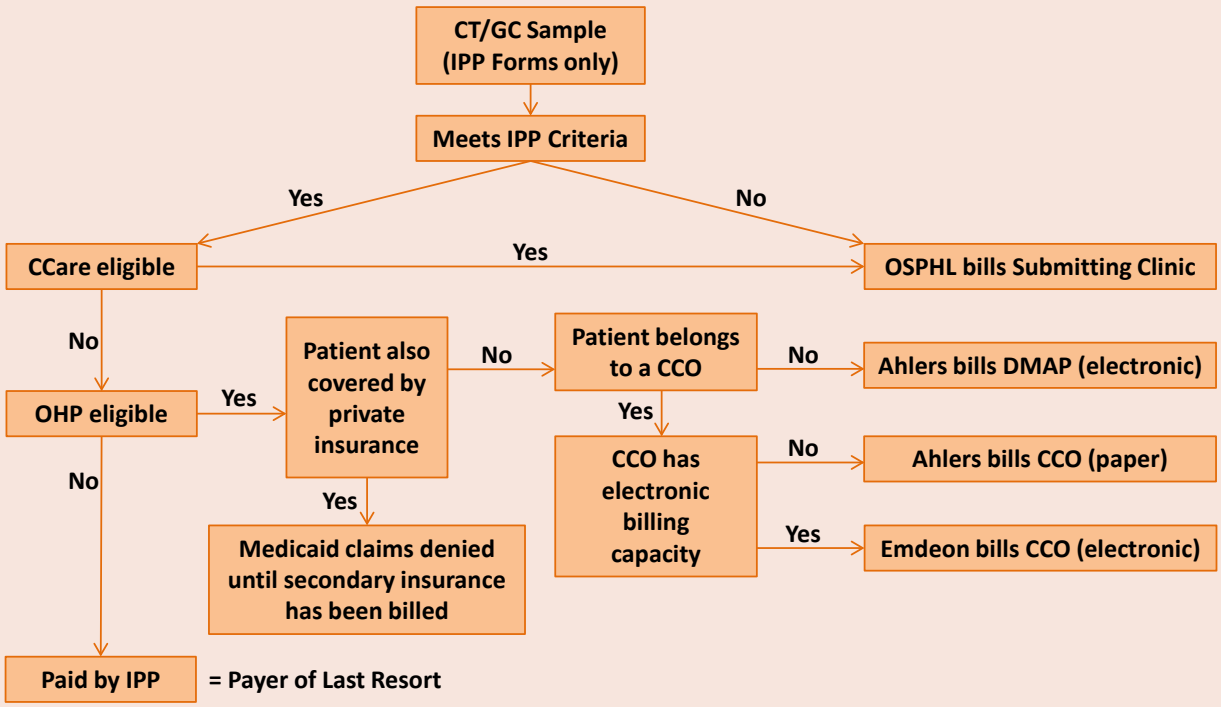
Once relationships with CCOs are in place, OSPHL must implement an increasingly complex billing system. At the time of this publication, OSPHL is piloting a new system to bill CCOs that utilizes both Ahlers and Emdeon, a billing clearinghouse. OSPHL is able to use Emdeon's services under an established contract between Emdeon and the State of Oregon. Ahlers now screens tests both for Medicaid eligibility and for CCO assignment. Tests for patients not belonging to a CCO are billed by Ahlers to DMAP. Ahlers also submits paper bills for tests covered by CCOs that are unable to accept electronic claims. Ahlers sends billing information for all other CCO-covered tests to Emdeon for electronic claims submission.

OSPHL is receiving some reimbursement through the CCOs. It will continue to test and improve the new billing sequence, develop relationships with additional CCOs, and explore options for outsourcing the entire billing process to a full service third-party billing company.

Lessons Learned—Improvement/Maintenance

- Identify, when possible, a point person to maintain and improve third-party billing operations
- Be aware that state and/or local policies may limit reimbursement rates, mandate billing pathways, prohibit billing for certain services, or pose other challenges to the maintenance or expansion of third-party billing
- Begin moving forward with third-party billing to position your program to adapt to the changing health care environment

Oregon State Public Health Laboratory Billing for Chlamydia/Gonorrhea Testing (2013)



OSPHL is motivated to meet new challenges and implement an efficient and effective third-party billing system. As discretionary government funding for public health laboratories declines at all levels, seeking third-party reimbursement for laboratory services will likely be essential to the long-term sustainability of the Oregon State Public Health Laboratory.

GLOSSARY

Coordinated Care Organization (CCO)—in Oregon, a network of health care providers (e.g., physical health care, addiction and mental health care, dental care) who have agreed to work together in their local communities to serve people who receive health care coverage under OHP/Medicaid. CCOs are local and operate under one global budget that grows at a fixed rate.

Current Procedural Terminology (CPT) code—a 5-digit code used to describe medical, surgical, and diagnostic services provided to a patient, established by the American Medical Association

Electronic Data Interchange (EDI)—in Oregon, a system for exchanging electronic data about health care transactions between DMAP, providers, and/or providers' authorized billing submitters

Healthcare Provider Taxonomy Code—designed to categorize the type, classification, and/or specialization of health care providers

International Classification of Diseases (ICD-9) code—a code used to describe patient diagnosis that is scheduled to be replaced by ICD-10 codes on October 1, 2014

IPP selective screening criteria—criteria used in the Region X IPP to identify those at greatest risk for CT/GC in Title X family planning clinics and other non-STD clinics. In Oregon, tests must meet selective screening criteria and be ineligible for payment through CCare or OHP to be paid for with federal STD funds.

Medicaid Provider Number—in Oregon, a six- or nine-digit number assigned by DMAP at the time of provider's enrollment with Medicaid that is required for billing Medicaid

Modifier—in CPT coding, a two-digit add-on placed after the usual procedure code number that adds clarification and additional details to the procedure code's original description and, at times, provides necessary explanation to third-party payers that directly relates to the reimbursement a provider will receive

National Provider Identifier (NPI) number—a unique 10-digit identification number for health care providers required by the Health Insurance Portability and Accountability Act (HIPAA) and assigned through the National Plan and Provider Enumeration System (NPPES). Providers use the same NPI number with all third-party payers.

Pooling—a laboratory testing strategy in which multiple specimens are tested simultaneously, followed by retesting of individual specimens if the pool yields a positive result. The decision to pool is based on the level of infection in the population of interest. In populations with relatively high CT or GC positivity, pooling is a less effective strategy for conserving lab resources.

Remittance—a statement accompanying payment from Medicaid and other third-party insurers, explaining payment details, covered charges, adjustments, and patient responsibilities and deductibles

Third-party payer—a public or private entity or program that is responsible for paying all or part of the expenses for medical care under a policy that details the terms of coverage. A third-party payer neither receives nor administers medical services.

Trading Partner Agreement (TPA)—in Oregon, a binding agreement between DMAP and the provider (and any entities authorized as submitters by the provider) that is required for exchanging electronic data about health care transactions