# CODING: FREQUENTLY ASKED QUESTIONS

**1. What is the best way to code for "high-intensity behavioral counseling" (HIBC) as recommended by the U.S Preventive Services Task Force (USPSTF)?**

The service for HIBC to prevent sexually transmitted infections (STI) was created by the USPSTF in response to the Affordable Care Act (ACA). The billing codes may not be the same for Medicare, Medicaid, and commercial payers:

- Medicare: Use billing code G0445 (20- to 30-minute session).
- Medicaid and commercial payers MAY accept G0445. If not, use billing codes for preventive medicine counseling (99401 - 15 minutes, 99402 - 30 minutes, 99403 - 45 minutes, 99405 - 60 minutes).

Diagnosis codes for all of the above payers include:

- V69.8 – Other problems related to lifestyle
- V74.5 – Screening for bacterial STI
- V73.89 – Screening for viral STI
- V64.45 – Counseling on other STI

It is permissible (but not reimbursed by every payer) to bill an evaluation and management (E&M) visit (99201-99215) in addition to HIBC if there is another separately identifiable service performed (for example, diagnosis and treatment of a urinary tract infection, breast lump, sore throat).

**2. What are your suggestions for billing V codes, which are often denied?**

V codes (V01-V91) are used to describe encounters for circumstances other than disease or injury for a patient that is not currently sick. These codes provide medical necessity to support screening or testing, or to identify circumstances that may increase a patient's potential risk for illness or injury. Because of the ACA, there are currently more covered preventive health care benefits available to all patients. Reimbursement for a preventive service in this situation requires a V code as a primary diagnosis.

However, based on the type and funding source of the health care insurance, there are limits to the amount and frequency of preventive services.

Payers expect counseling, risk factor reduction, and anticipatory guidance to take place during these visits, but not necessarily during a problem-oriented E&M visit (99201-99215). Reimbursement difficulties occur if there is a mismatch between type of visit (prevention vs. problem) and reason for the visit (screening vs. illness).

When billing E&M visits (problem focused), it is critical to provide medical necessity. For example, if a patient presents to a STI clinic with discharge and screening or testing is required, use the ICD9 code for the sign or the symptom, not the ICD 9 code for screening.

**3. How can we code for pre-exposure prophylaxis (PrEP)?**

PrEP is a way for high-risk patients without HIV to prevent infection by taking medication every day. When a provider counsels and prescribes the HIV prophylactic medication, use billing codes for preventive medicine counseling (99401- 15 minutes, 99402 - 30 minutes, 99403 - 45 minutes, 99405 - 60 minutes).

There are multiple diagnosis codes that may be used to provide medical necessity:

- V69.2 – High-risk sexual behavior
- V01.79 – Exposure to other viral diseases
- V01 – Contact with or exposure to communicable diseases
- V15.85 – Exposure to potentially hazardous body fluid
- V01.8 – Exposure to other communicable diseases
- V01.9 – Contact with or exposure to unspecified communicable disease
- V07.8 – Other specified prophylactic measure
- V58.83 – Encounter for therapeutic drug monitoring
- V07.9 – Unspecified prophylactic measure
- 70.3 – Hepatitis, viral, type B (acute) without hepatic coma
- V02.61 – Hepatitis, viral, type B carrier status
- 70.32 – Hepatitis, viral, type B, chronic
- 70.31 – Hepatitis, viral, type B, delta

Once PrEP is provided, if a patient returns due to the side effects of treatment, use E&M billing codes (99212-99215). Use the appropriate ICD9 code for the sign or symptom related to the complaint.

**4. Are there sample protocols or policies for having a quality assurance plan in place for coding and billing?**

A thorough compliance plan is the best way to ensure quality and excellence in your coding and billing practice. The Office of the Inspector General (OIG) provides guidance for this a OIG Compliance Plan for Small Group Physician Practices. The OIG recommends a comprehensive plan that includes these seven basic components:

1. Conducting internal monitoring and auditing through the performance of periodic audits
2. Implementing compliance and practice standards through the development of written standards and procedures
3. Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards
4. Conducting appropriate training and education on practice standards and procedures
5. Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities
6. Developing open lines of communication. Examples include:
    a. Discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct
    b. Community bulletin boards to keep practice employees updated regarding compliance activities
7. Enforcing disciplinary standards through well-publicized guidelines

It's worth investing time to create a compliance plan, as it may be your best defense when you are audited. There are many free templates on the internet that will allow you to customize a program that meets your needs and includes all seven of these components. There is also one posted in the billing toolkit: http://stdtac.org/wp-content/uploads/2016/05/OIG-Compliance-Plan-for-Small-Group-Physician-Practices.pdf.

## 5. What steps can clinics take to be prepared for an audit?

The incidence of governmental and commercial health insurance audits has increased significantly in the last several years. It is likely that every clinic or practice will be audited at least once during its business lifetime.

There are several things you can do to stay ready for an audit:

1. Create and execute a compliance plan.
2. Compare your E&M bell curve to Medicare's bell curve. Each year the Centers for Medicare and Medicaid Services publishes utilization data for all E&M codes based on the claims they allowed the two prior years. Statistics are presented by provider type, not clinic type, so it may be difficult to compare apples to apples. However, once plotted on a bar chart, significant coding outliers will be evident.[1,2]
3. Become familiar with your **Medicare** Administrative Carriers' medical review (audit) process and outcomes. For example, National Government Services posted the audit results of approximately 3,000 level 5 office visits for established patients (99215).[3]
4. Become familiar with your **Medicaid** Recovery Audit Contractor program. The ACA requires every state to contract with one or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping those overpayments.[4]
5. Each year the OIG publishes a work plan that announces their target areas for payment recovery from federally funded programs.[5] You will find this year's audit focus in part 1 (Medicare) and part 3 (Medicaid). In 2015, **Medicare** plans to direct reviews of "new" versus "established" E&M services. **Medicaid** will target billing practices to ensure that when there is more than one third-party payer, Medicaid remains the payer of last resort.
6. It helps to know where the biggest faults lie. Eighty-three percent of audit deficiencies are due to lack of documented medical necessity, 10 percent as a result of improper coding, and five percent for insufficient documentation. Providers should document their medical decision making or reasoning when it is not completely obvious.

[1] http://stdtac.org/wp-content/uploads/2016/05/EMSpecialty2012.pdf
[2] http://stdtac.org/wp-content/uploads/2016/05/EM_Bell_Curve.xls
[3] http://stdtac.org/fwp-content/uploads/2016/05/NGS-Medical-Review.pdf
[4] http://w2.dehpg.net/RACSS/Map.aspx
[5] https://oig.hhs.gov/reports-and-publications/workplan/

7. Commercial payers do not broadcast their audits as well as federal programs do, however sometimes it is possible to find audit policies and results on their websites.[6]
8. If you are asked to respond to a notification of an audit, follow the specific procedure mandated by the individual payer. Keep copies of all responses and receipts of any documents sent to the payer. If you are concerned about a significant shortcoming or deficiency at your clinic, consider hiring an outside consultant to perform a defensive audit to mitigate your risk.

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[6] http://stdtac.org/wp-content/uploads/2016/05/Athem-Audit-Policy.pdf