

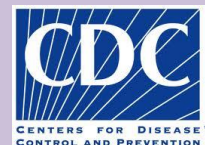
RESOURCE MANUAL

Nevada



For the Public Health Departments of Nevada

A Guide to Successful Billing



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Disclaimer

This document represents a collective effort to provide a guide on billing health insurance for Public Health services. Billing processes and websites change frequently. Information provided in this document was current at the time it was collected.

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Section I. Introduction

1.1. Background

In Nevada the program responsible for overseeing all immunization practices is the Nevada State Immunization Program (NSIP). The NSIP is federally funded by the Centers for Disease Control and Prevention (CDC), and operates under the direction of the Nevada Division of Public and Behavioral Health (DPBH) within the Department of Health and Human Services.

The NSIP oversees all aspects of vaccines in Nevada, including but not limited to:

- Vaccines for Children (VFC) Program
- Special Projects
- Perinatal Hepatitis B Prevention
- Nevada Web IZ, which is a statewide immunization registry

On December 13, 2011, the NSIP was awarded a grant from the Centers for Disease Control and Prevention to create a strategic plan for billing for immunizations at public health departments across the state. The NSIP contracted Carson City Health and Human Services to execute this grant. The grant was fully funded through grant # IP11-1107PPHF11.

In order to understand the significance of this grant to the state of Nevada, a little historical perspective is necessary. Historically Nevada has had some of the lowest immunization rates in the United States. There are many factors contributing to this outcome, including a lack of access to healthcare providers offering vaccines due to the significant financial burden associated with purchasing, storing and maintaining vaccines. Public health was not immune to this burden; however, most avoided it by not carrying private vaccine, continuing to depend on state supplied vaccines through the Vaccines for Children and Section 317 programs.

317 Program

The 317 program has historically provided funding to support State immunization infrastructure and operation costs, as well as many of the vaccines provided by public health departments. This fund also covers individuals that are not eligible for the Vaccines for Children (VFC) Program, and includes individuals that are uninsured or whose primary insurance doesn't cover the costs of the vaccine.

Due to the decrease in federal funding for 317 vaccines, a statement came out by the CDC advising parents that as of October 1, 2012, insured children receive their immunizations from their primary healthcare provider. If their insurance does not cover immunizations, or their primary care provider does not provide vaccines, or the child is VFC-eligible, they can continue to receive their

immunizations at their local health departments.³ There are additional exceptions where 317 vaccines may continue to be used to vaccinate adults and children:

- Hepatitis B birth dose – vaccine costs can be divided between VFC and 317 funds
- Pandemic exercises, such as Points of Dispensing (POD) events
- Outbreak situations (regardless of insurance status)
- Disaster relief efforts
- Post-exposure prophylaxis

The Nevada State Immunization Program will continue to use section 317 vaccines for:

- Adult Tdap for cocooning in birthing hospitals and OB/GYN clinics
- Adult influenza for cocooning in OB/GYN clinics
- Twinrix for high-risk adults
- Adult vaccines for uninsured and underinsured adults

Vaccines for Children Program

The Vaccines for Children (VFC) Program, created in 1994 by the federal government through the Omnibus Budget Reconciliation Act (OBRA), is a federal entitlement program aimed at improving vaccine availability. The VFC Program provides free vaccination to children whose parents or guardians cannot financially afford to vaccinate their children, and is allocated for children from birth through 18 years who meet at least one of the following criteria:

- Currently enrolled in or are eligible for Medicaid
- Enrolled in Nevada Check Up Program
- Have no health insurance coverage
- Are underinsured*
- Are American Indian, Native American, or Native Alaskan

If a child is eligible for the VFC Program, they are entitled to receive the full immunization series recommended by the CDC's Advisory Committee on Immunization Practices (ACIP)

**Underinsured – the child's current health insurance doesn't cover vaccines or doesn't guarantee coverage for required vaccines, or covers vaccines but there is a deductible that must be met first before there is coverage for the vaccine. Children that are underinsured will have to go to a deputized provider for any VFC vaccines as of January 1, 2013.*

Parents or guardians can obtain their child's vaccinations in three primary ways:

1. If the child is VFC eligible, they can receive their vaccines from a VFC provider at no charge, but they will be charged for administrative fees**
2. Visit a community clinic that offers vaccinations, which may be at a reduced price and also administration fees may be waived or less than those at a Private provider
3. Visit a Private provider that offers privately stocked vaccines

***In the State of Nevada the administrative fees associated with a VFC vaccine is capped at \$22.57 per vaccination.*

With the extent of Federal funding decreases over the past several years, local public health officials realized that there was a greater need than ever to adapt to the times and address the need for a billing infrastructure. The goal was to develop a method to bill those with insurance, thus increasing availability of federally funded vaccines to those with the greatest need.

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1.2 Grant Overview

Carson City Health and Human Services, in collaboration with the State Immunization Program, developed an operational scope of work to fulfill the goals of the grant. The mission of the project was to transition to billing insurance as seamlessly as possible while continuing to deliver the highest level of care to clients.

The following is a copy of the scope of work used as a guide to assist with meeting the overarching goals of the billing planning grant. It is important to note that it was a guide only and the timelines were scalable where needed.

The following are the objectives set forth in the Scope of Work:

- Objective 1: By November 2012, collect data on the current status of immunization billing in Nevada
- Objective 2: By October 2012, perform capacity integration and cost analyses of major systems for billing third party payers for immunization services
- Objective 3: By August 2013, determine the best system(s) to bill private and public insurers for vaccine and the administration fee, as appropriate, and develop an action plan for state health division clinics and local health departments to efficiently and cost-effectively implement billing third party payers for immunization services.

Objective 1) By November 2012, collect data on the current status of immunization billing in Nevada			
Activities	Outcomes, Documents, Reports	Evaluation	Timeline
1. Conduct a literature search of Nevada laws and regulations relative to immunizations and billing processes and authority. Publish a summary of findings.	A synopsis of the laws and regulations governing the insurance industry, the authority for immunizations and billing processes.	The information will be evaluated for its completeness and relevance as it is reviewed by NSIP in establishing the current landscape.	February 2012
2. Create and administer a survey for health department clinics to determine patient insurance status. The survey will need to capture age, zip code, insurance status and, if privately insured, the insurance company, group number, contact information, and co-payment information.	A report on patient insurance status in Nevada, including percentage of patients with insurance, and the breakout of the insurance carriers, including Medicare, Medicaid and Nevada Check Up.	The survey tool will be evaluated to ensure it will capture the necessary information; the report will be assessed as to its effectiveness when performing the analysis of the data and using it to estimate the potential revenue that can be generated by billing third party payers that are not currently being billed.	May 2012
3. Research the payer policies and regulations of the third party payers identified from the patient insurance status survey, including billing companies, clearinghouse and/or software that they work with, credentialing requirements and reimbursement rates.	A matrix detailing the third party payer policies covering billing practices, software or electronic filing processes, credentialing requirements and reimbursement rates.	NSIP management will evaluate the document for comprehensiveness of information and the relevance of data to accomplish a financial analysis/comparison of third party payers.	Nov.2012
Objective 2) By October 2012, perform capacity integration and cost analyses of major system(s) for billing third party payers for immunization services.			
Activities	Outcomes, Documents, Reports	Evaluation	Time
1. Evaluate the electronic medical records systems currently in use for feasibility of enhancing interoperability with the state immunization registry, Nevada WebIZ, using Health Level 7 (HL7) standard messages.	Envision, the contractor for Nevada WebIZ, will generate a report that identifies specific EMRs and their capability of interfacing with Nevada WebIZ, including costs for integration.	NSIP and health department management will analyze the report to determine feasibility and financial cost for possible integration of systems with Nevada WebIZ.	July 2012
2. Analyze the advantages / disadvantages of using roster billing with the insurance carriers.	There will be at least three proposals for the workgroup to compare using a standardized evaluating tool that will be developed under the direction of NSIP management.	NSIP will incorporate the findings from this evaluation into the report generated by proposals from third party billers to provide immunization billing services.	August 2012
3. Request proposals from third party billers to provide immunization billing services.	There will be at least three proposals for the workgroup to compare using a standardized evaluation tool that will be developed under the direction of NSIP management.	NSIP will write a report summarizing the results of the evaluation of the proposals and present the information to the health departments.	September 2012
4. Provide the community, providers, health department and third party payers' and other stakeholders a status report summarizing the findings resulting from capacity integration and cost analyses of major system(s) for billing third party payers for immunization services.	Ideally, the goal will be to have a face-to-face meeting supported by videoconference. However, if this is not possible, the report will be mailed to stakeholders	NSIP management will review feedback obtained from stakeholders.	October 2012

Objective 3) By August 2013, determine the best system(s) to bill private and public insurers for vaccine and the administration fee, as appropriate, and develop an action plan for state health division clinics and local health departments to efficiently and cost-effectively implement billing third party payers for immunization services.

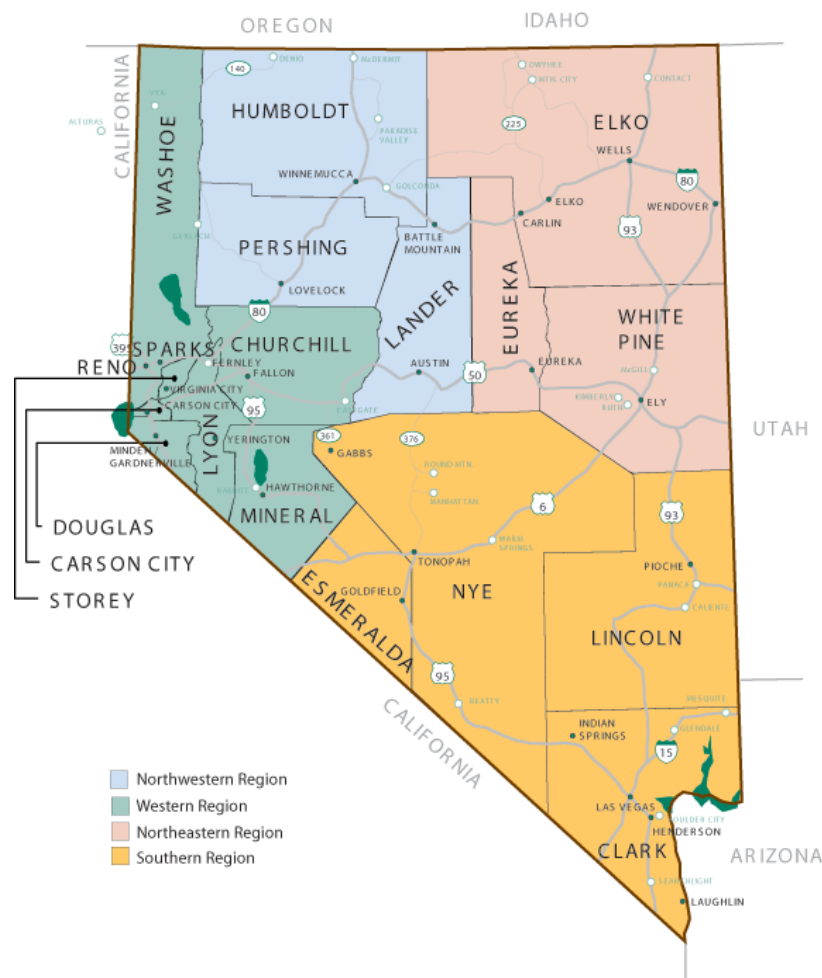
Activities	Outcomes, Documents, Reports	Evaluation	Timeline
1. Develop draft strategic plan for billing third party payers for immunization services based on results of patient insurance status surveys, evaluation of health department billing processes and capabilities, review of third party payer system proposals, and analysis of the cost-effectiveness and return on investment of the billing systems under consideration.	NSIP will publish the draft strategic billing plan.	NSIP management and leadership from Nevada's health departments will review and provide input on the drafted billing plan.	January 2013
2. Identify and create pilot group of third party payers to evaluate strategic billing plan for immunization services.	There will be a minimum of 5 third party payers identified in the pilot group.	Appropriate credentialing will be completed and contracts will be in place to ensure ability to bill for immunization services provided by health department clinics.	February 2013
3. Develop billing policies and procedures incorporating the health departments' delivery of immunization services practices. Create documentation and train appropriate staff regarding the billing processes.	Billing specialists in the pilot will have been trained and received for reference a "cheat sheet" outlining the process for billing third party payers. The pilot group of third party payers will each have assigned a representative as the point person for the project who has been briefed and is an available resource once the pilot begins.	Project Manager will review training / education plans to ensure alignment with processes developed in strategic plan and procedures of third party payers.	March 2013
4. Begin submitting immunization claims to pilot group of third party payers to evaluate processes, costs and accuracy.	Successfully receive reimbursement for immunization services provided by health department clinics. However, we expect that there will be some problems that will help us discover what we need to change and improve to be successful.	A feedback form will be developed for the billers to complete and submit for review. NSIP and health department staff will perform a cost benefit review as relates to the billing processes and make recommendations for modifications to the strategic plan.	April 2013
5. Modify strategic plan(s) for billing for immunizations services based on pilot group's input.	Publishing of a statewide strategic plan for billing for immunization services provided by health department clinics. The plan will include billing policies and procedures, financial analysis, suggested implementation guidelines and timeframes.	NSIP management and leadership from Nevada's health departments will review and provide input to the billing plan.	July 2013

<p>6. Modify and enhance the billing training plan.</p> <ul style="list-style-type: none">a. incorporate a train the trainer model that can be used by health departments to train billing and support staffb. train all appropriate public health department personnel	<p>Publishing a statewide training manual and developing a core group of trainers. Provide documentation of all trainings.</p>	<p>NSIP management, leadership from Nevada's health departments, and billing representatives will review and provide input to the training plan.</p>	<p>August 2013</p>
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1.3 Snapshot of Nevada

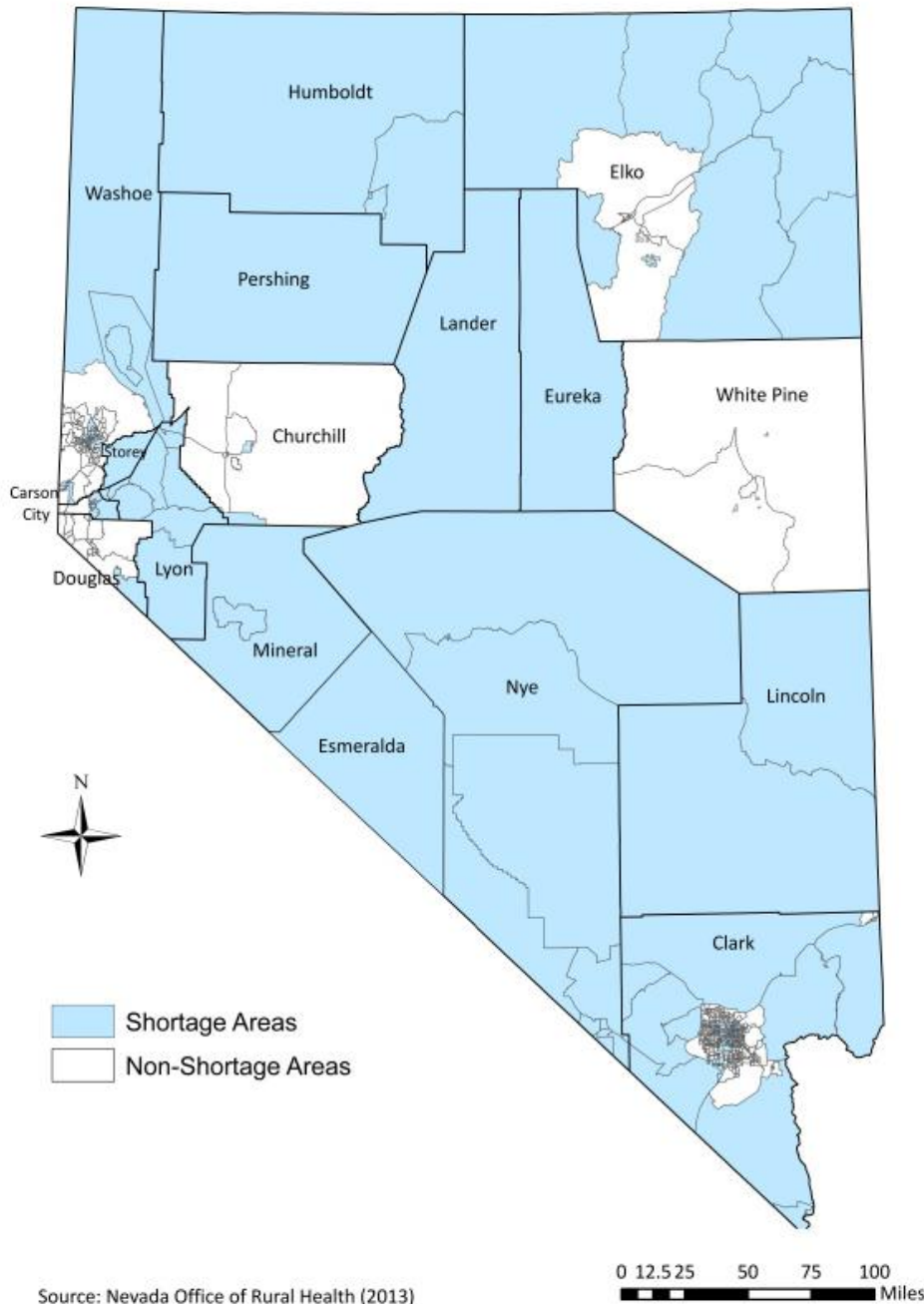
Nevada, the 36th state, was admitted to the Union in 1864. It is the 7th state in size but only 35th largest in population, with a population of 2.7 million according to the 2010 census. There are 17 counties, three of which are considered urban (population , 50,000), comprising 92% of the state's population. The remaining 14 rural counties encompass 8% of the population. Nevada has three local health authorities, Carson City Health and Human Services (which serves Douglas County, as well); Washoe County Health District, and Southern Nevada Health District, which includes all of Clark County (with 1.95 million people). The Nevada Division of Public and Behavioral Health Community Health Nursing clinics serve the remaining 13 rural counties.

The following map depicts the counties of Nevada.



Map from www.county-map.blogspot.com

Unfortunately, there is a significant access to healthcare problem in Nevada, due in part to the vast amount of land and relatively small population. The following is a map portraying the healthcare inaccessibility, which shows that with the exception of six areas, the entire state is a shortage area. In 2013, 36% of Nevada's population was in a healthcare shortage area.



The poverty level in Nevada is at 15.9%, which is .9% below that of the national average according to the 2012 U.S. Census. This makes the case for the importance of conserving the dwindling 317 vaccine funds for those in most need. Creating a billing infrastructure to serve those clients that do have insurance will aid in that goal.

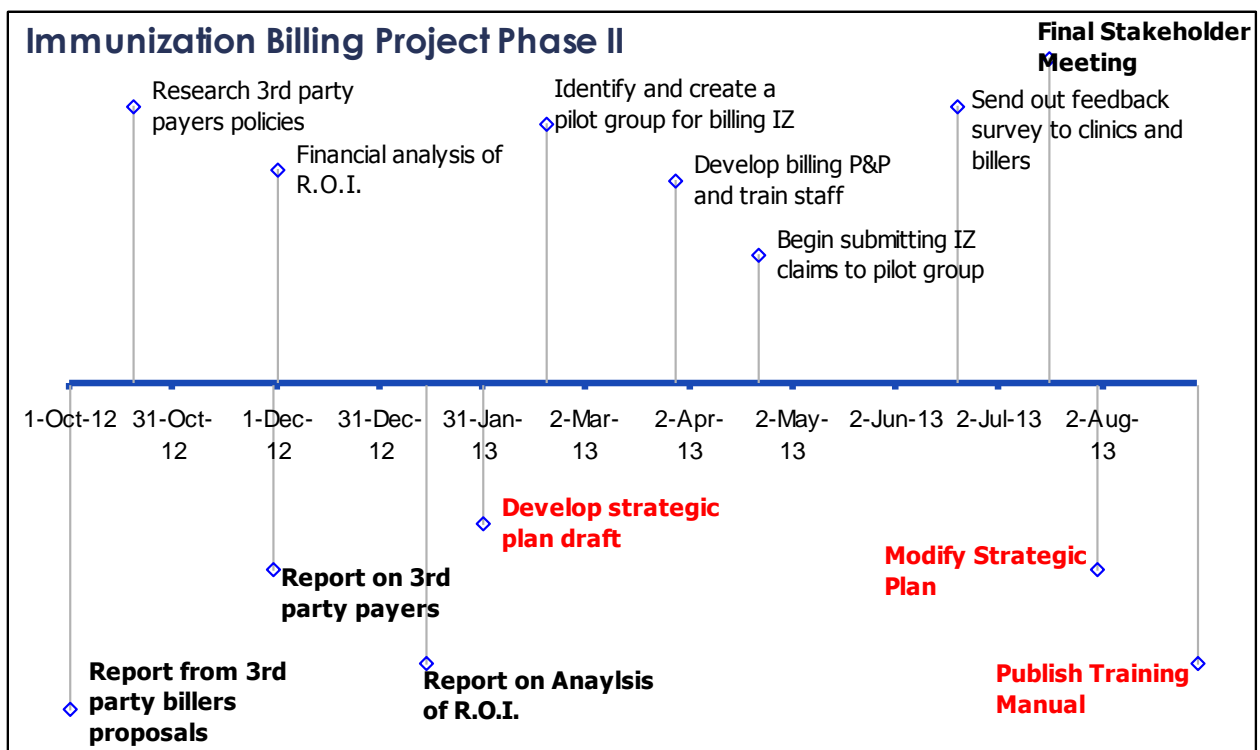
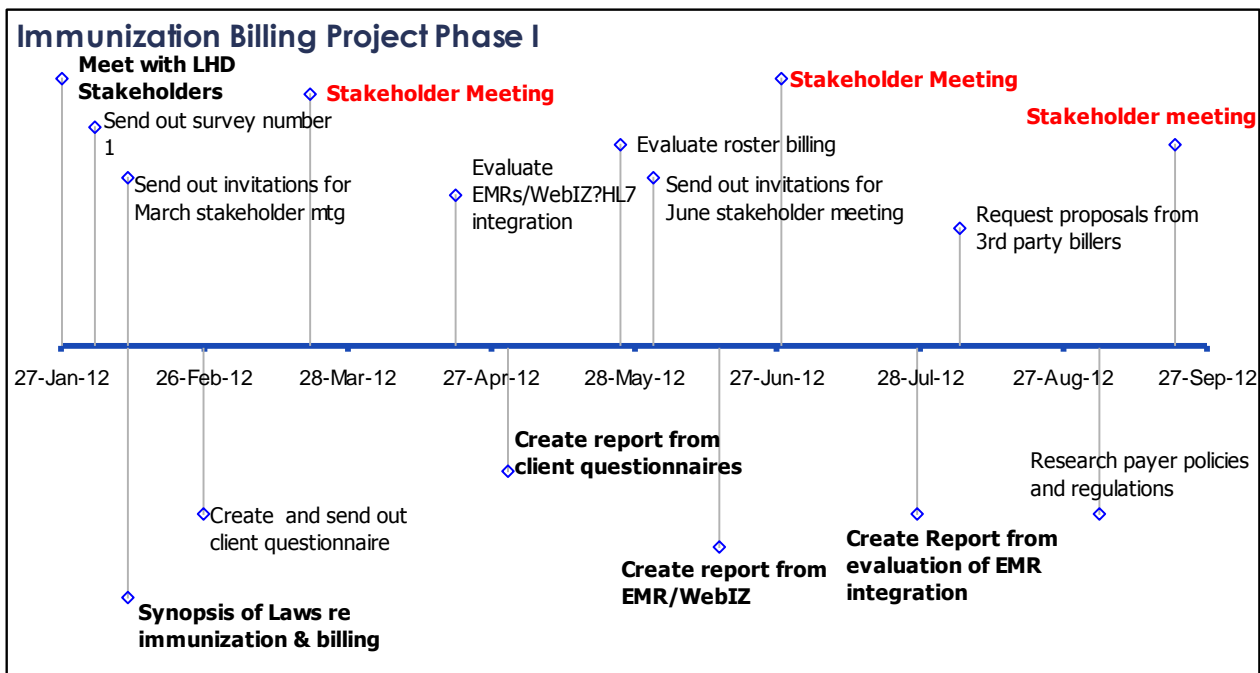
At the inception of this grant project, Nevada's public health departments had a limited capability for billing private and public health insurances. The following statements aided in providing support for billing in Public Health in Nevada.

- ❖ In 2010, 41 % of all vaccine doses administered in Nevada health departments were given to insured children. Due to the lack of a billing system, these vaccine doses were not billed to third party payers, which resulted in a significant loss of revenue.
- ❖ More third party payers are now offering immunization coverage, but without a robust billing infrastructure, public health departments are unable to bill for these services.
- ❖ Historically, federally subsidized immunization programs have been able to provide free immunizations for all regardless of ability to pay; this is no longer the case.
- ❖ With the passage of the Affordable Care Act, more people will be eligible for insurance coverage for immunizations, which makes it imperative to have a plan to bill insurances and ensure federal funding is there for those who still need it.
- ❖ The cost of immunizing a child has increased from \$1,382 in FY 2011 to \$1,472 in FY 2012; therefore, development of this plan is imperative to help families protect their children and for our local public health departments to continue to thrive in this troubling economy.

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1.4 Getting Started

When Carson City was awarded this project from the State, it was deemed important to have a timeline to ensure a structured and successful endeavor. The following is a copy of the timelines which were used as a guide for organizing the progress of the project.



1.4.1 Legal Review

A rigorous review of the Nevada Revised Statutes and Nevada Administrative Codes was performed in order to ascertain whether there were any potential legal barriers to billing in public health departments. The Nevada Revised Statutes (**NRS**) are the current codified laws of the State of Nevada, and are a compilation of all legislation passed by the Nevada Legislature during a particular Legislative Session. The Nevada Administrative Code (**NAC**) is the codified, administrative regulations of the Executive Branch. The result of this review was that there were no barriers, but in researching the laws, the staff uncovered some statutes and codes which are important to share. The following is an overview of those findings. This is a synopsis only; the actual laws are cited and can be found at www.leg.state.nv.us/NRS and admin.nv.gov/NA.

The most applicable ones to immunization administration and billing are highlighted for quicker reference.

Chapter 422 –Healthcare Financing and Policy:

The HPV vaccine must be included in the State Plan for Medicaid for the state to pay the nonfederal share of expenses incurred for administering the HPV vaccine to women and girls at the recommended ages. NRS

422.2718

Chapter 439 – Administration of Public Health (*a description of how Nevada’s health districts versus health departments are determined*)

Administration (defined); powers and duties - *The State Board of Health has general supervision over all matters (with the exception of administrative) related to the preservation of health and lives of the citizens and over the work of the Health Officers and all health departments, and boards of health. The State Board of Health can pass regulations which will supersede all local ordinances and regulations and have the effect of law. Each county shall establish a board of health whose officers serve without additional compensation. These officials will, with the approval of the county commissioners, set a schedule of fees for health permits and licensing. They will also effectively restrain quarantine and disinfect persons with contagious diseases that are deemed dangerous to the public’s health. NRS 439.150, 200*

For counties with population of 700,000 or more, there are set guidelines for who shall be on the board of health. They can only serve a 2 year term. The District board of health replaces any city, county or town board of health and if they exist, they must be abolished. The powers and duties of the district board of health are the same as those of the county. The district board can adopt regulations consistent with the law with a majority vote and by approval of the State Board of Health to prevent and control nuisances, regulate sanitation, promote and protect public health, and improve the quality of healthcare services for minority groups and medically underserved populations. NRS 439.361,362,366

*For counties with population of 700,000 or less, a District board of health can be created consisting of boards of county commissioners in any two adjacent counties, governing bodies of two or more cities or towns within any county, or both; with approval of the State. The District board of health replaces any city, county or town board of health and if they exist, they must be abolished. Members must include two members from each representing city or county, plus an additional member who is a licensed physician who can practice medicine in the state. The board shall appoint a district health officer. The powers and duties of the district board of health are the same as those of the county. The district board can adopt regulations consistent with the law with a majority vote and by approval of the State Board of Health to prevent and control nuisances, regulate sanitation, and promote and protect public health in the jurisdiction. A thirty day notice must be given before any regulation can be adopted, amended or repealed and filed with the county clerk or each county of the jurisdiction. **NRS 439.369, 380, 383, 385,390,400 and 410***

*City boards of health are created by ordinance. Cities with a population of categories one [50,000 or more] or two [5,000 – 49,999] shall provide by ordinance for the establishment of a board of health. Cities with a population category three [< 5,000] may provide by ordinance for the establishment of a board of health. Duties include: oversight of sanitary conditions in city, adopt regulations as necessary for prevention, suppression, and control over infectious diseases and have been approved by State Board of Health. After approval of regulations, file copy with city clerk. Powers include: abate nuisances, establish a quarantine isolation hospital or station for when emergency demands so; restrain, quarantine and disinfect any person with or exposed to an infectious disease. The city shall pay all debts or charges incurred with the exception (if the person is able to) pay for food, medicine, clothing, or medical attendance. The board shall also adopt a fee schedule for issuing or renewing health permits and licenses for the sole purpose of defraying cost and not purposes of general revenue. **NRS 439.420,460,470***

Immunization Clinics

*Immunization clinics must be held before the start of school by either the county, city, town or district boards of health and those administering vaccines in good faith and without gross negligence are immune from civil and criminal liability. **NRS 439.535***

Health Information Exchange

*The Health Information Exchange is defined as a system for movement, storage, analysis and exchange of electronic health records. **NRS 439.586** As long as a covered entity follows the regulations set by the Health Insurance Portability and Accountability Act of 1996, they are exempt from any more stringent state laws. **People may opt out of electronic disclosure of health information UNLESS they are a recipient of Medicaid or CHIP. NRS 439.538** The Director is the state authority of health information technology and is responsible for regulating and managing health information exchange. **NRS 439.587** The health information exchange will be governed by a*

non-profit entity for which the director will set the requirements. **NRS 439.588** Regulations must be followed in order to preserve the confidentiality and privacy of health information in electronic health records. All federal laws governing electronic health records must also be adhered to. **NRS 439.589** Providers must comply with the regulations for use of the statewide health information exchange system. **NRS 439.590** Electronic health information records must be maintained and transmitted in compliance with confidentiality requirements. **NRS 439.592** Healthcare providers are immune from liability when they have based their care on information provided within the System as long as they are not responsible for the inaccuracy of the record and their decision was appropriate care. **NRS 439.593**

Immunization Information System

The provider must give a form which provides notice to patients and/or parents of patients receiving immunization services that their information will be entered into the immunization registry. **NAC 439.883** A provider must provide notice to adults regarding system, contents and ability of adult to opt out of system. **NAC 439.885** Providers may report immunizations not reported or recorded in the System prior to July 1, 2009, and also may request removal of records **NAC 439.887** The Department shall establish an Immunization Information System to be administered by the State Board of Health into which any person administering immunizations to a child after July 1 2009 must enter the name, age, gender and race and any other requirements from the Centers for Disease Control and Prevention and other government entity. **NRS 439.265** Providers must abide by the guidelines set forth for reporting of information for vaccines given to children. The information to be entered in the System will include child's date of birth and address, county state and country where born. Also must include mother's full name, lot number and manufacturer of vaccine given. **NAC 439.890** Providers must abide by the guidelines set forth for reporting of information for vaccines given to adults. The information to be entered in the System will include adult's date of birth and address, county which resides, state and country where born. Also must include gender, race and ethnicity, lot number and manufacturer of vaccine give. **NAC 439.893** Information contained in the health information system is maintained as confidential and is limited to those in healthcare, schools, the Department, an insurer, a child welfare agency and the Department of Corrections. **NAC 439.895** An immunization record provided by the immunization system is deemed an official certificate. **NAC 439.897**

Rural Clinic

A rural clinic is defined as a facility that lies in an area not declared urban by the Bureau of Census where medical services are provided by either a physician assistant or advanced practitioner of nursing under the supervision of a physician. **NRS 449.0175**

Community Health Nurse Services

Services provided by Community Health Nurses for patients that do not qualify under other grants, will be charged discounted rates based on Federal Poverty Level. NAC 439.500

Chapter 439B

Restraining Costs of Healthcare:

Children's health insurance program (CHIP) is defined as children of low-income families. NRS 439B.035 Under the program to increase awareness of healthcare programs for children, preventive healthcare measures which must be emphasized include: a) The benefits of preventive healthcare services to the well-being of children; and (b) The reasons that preventive healthcare services are more efficient in treating potential healthcare needs and are more economical than obtaining emergency healthcare services which are often required when symptoms of an illness are not promptly and properly treated. NRS 439B.350

33Chapter 629 – Healing Arts Generally

Provider must furnish patient with a timely itemized bill for services rendered. NRS.629.071 Commissioner of Insurance to develop standardized form for use by insurers and other entities to obtain information related to credentials of certain providers of healthcare. [Effective January 1, 2012.] NRS 629.095 Each insurer, carrier, society, corporation, health maintenance organization and managed care organization shall use the Nevada Division of Insurance Form 901 when obtaining credentialing information for healthcare providers. NAC 679B.0405

Chapter 679B – Commissioner of Insurance

The Commissioner shall adopt regulations which require health insurers to use uniform claim forms and billing codes and the ability to make compatible electronic data transfers. NRS 679B.138 The legislature finds that it is necessary to establish a comprehensive system to collect, analyze and distribute information concerning the cost of insurance in order to contain costs. NRS 679 B.400 The Commissioner shall determine the relationship of premiums and related income of insurers to costs and expenses of insurers and provide this information to the Legislature. NRS 679B.410

Chapter 689A - Uniform Health Policy Provision Law

A policy of health insurance must not be delivered or issued for delivery to any person in this State unless it otherwise complies with the Insurance Code as stated in NRS 689A.030 Contracts between insurer and provider of healthcare prohibits insurer from charging healthcare provider a fee to include them on a list for their insured. NRS 689A.035 Certain gynecologic and obstetric services must be covered without a referral or prior authorization by the insured's Primary Care Provider. NRS 689A.0413 Contraceptive and hormone replacement therapy drugs, devices and outpatient care will be covered unless insurance carrier has a religious objection and

in that case the insurance company must notify the insured in writing of refusal to provide for such. **NRS 689.0415, .0417** *Costs incurred with administration of the Human Papillomavirus Vaccine for those girls and women in the age range that the authority determines is recommended must be covered without a prior authorization.* **NRS 689A.044** *All insurers must accept claim forms from any individual licensed to practice one of the health professions regulated by Title 54 of NRS as long as those forms are uniform as prescribed by the Commissioner, except where the Commissioner has excused uniform reporting.* **NRS 689A.105** *An insured person can assign his or her rights to benefits to the healthcare provider who provided services covered by the policy. If the insurer pays the insured, he must also pay those benefits to the provider of healthcare as soon as he receives notice of incorrect payment.* **NRS 689A.135** *There are set guidelines for what defines creditable coverage with respect to a person and health benefits, including but not limited to group health plan, Medicare, Medicaid, CHIP, CHAMPUS and state health benefit pool.* **NRS 689A.505** *“Group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care to the employee or their dependents as defined by the plan or through insurance, reimbursement or otherwise, except for those terms stated in* **NRS 689A.535** *“Health benefits plan” means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver, arrange for payment and pay or reimburse any costs of healthcare services.* **NRS 689A.540** *“Individual health benefit plan” means a plan for individuals and their family in which the person pays the premium.* **NRS 689A.555** *“Pre-existing condition” is defined a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months preceding the effective date of coverage.* **NRS 689A.585** *All insurers which provide accident and health insurance, medical and dental service corporations, health maintenance organizations, and other organizations which accept prepayment for health services must accept forms approved by the Division for the administration of benefit payments. They may request from the Division a change in the form.* **NAC 689A.310, .330, .350** *All plans must define preferred providers and provide the insured a list of same, also informing them of the differences in charges if seen by a non-preferred provider.* **NAC 689B.120**

Chapter 695C – Health Maintenance Organizations

Health maintenance organization (HMO) is any person which provides or arranges for provision of healthcare, which services are paid for or on behalf of the enrollees. Provider means any physician, hospital or other person who is licensed or otherwise authorized in this state to furnish healthcare services. **NRS 695C.030** *A HMO must use the form created by the Commissioner to contract with a healthcare provider. Schedule of payments must be provided upon request to the provider within 7 days of the request. Any changes to the schedule of payments must be requested in writing 45 days prior.* **NRS 695C.125** *Any Medicaid HMO or CHIP plan must pay interest on*

any claim that is not paid within the time provided in the contract. **NRS 695C.128** An HMO must approve or deny a claim within 30 days of receipt and then, if approved, must pay within 30 days. If the HMO is in need of additional information, it must submit in writing the request within 20 days of receiving claim. If these requirements are not met, the Commissioner may impose a fine upon the HMO. **NRS 695C.185**

Chapter 695G – Managed Care

The definition of managed care is a system for delivering healthcare services that encourages efficient use of those services including but not limited to providing utilization review and offering financial incentives. **NRS 695G.040** A “provider of healthcare” is defined as any physician, hospital or other person who is licensed or otherwise authorized in the state to furnish any healthcare service. **NRS 695G.070** A healthcare plan issued by a managed care organization must provide for coverage for benefits for costs incurred with administration of the HPV vaccine, and cannot require a prior authorization. **NRS 695G.171** Contracts between a managed care organization and provider of healthcare must utilize the form the Commissioner prescribes. If there are any requests for modifications, they must be made in writing within 45 days. **NRS 695G.430**

Chapter 695H – Medical Discount Plan

The definition of a medical discount plan is an arrangement between a client and a plan that for a fee offers clients discounts in healthcare services with providers that have agreed to those discounts. This is not a health insurance. **NRS 695H.050**

Chapter 695I – Silver State Health Insurance Exchange

The Silver State Health Insurance Exchange is being created in agreement with the Affordable Care Act (ACA) in order to facilitate purchase and sale of qualified health plans, to assist qualified small employers in enrolling, purchasing coverage and applying for subsidies. In agreement with the goals of the ACA, it will assist residents with access to programs of healthcare insurance and ultimately decrease the number of uninsured people in the state of Nevada. **NRS 695I.200, .210** The regulating board and the Department of Health and Human Services will work with the exchange to ensure they coordinate with state insurance plans such as Medicaid and CHIP to create a single point of entry for those people that qualify. **NRS 695I.390** The Department of Health and Human Services, the Division of Insurance and Industry and other governmental agencies will work with and support the Exchange in order to help them facilitate their goal. **NRS 695I.500**

1.4.2 Stakeholders

Being such a new concept to our public health departments, the project team felt it was very important to reach out to individuals and organizations that may have an interest in becoming a stakeholder. This partnership not only allowed these stakeholders to have a voice in the process and decisions made but also allowed feedback to the project management team. This new notion of clinic's billing private insurances needed all the support it could achieve.

When initially approached, many of the stakeholders asked: "What will I need to do?" This is an understandable question due to the fact that they were had other commitments and if this project demanded too much of their time, they would not be able to participate. In order to accommodate everyone's busy schedule yet to maintain support, the project manager decided to hold meetings quarterly and give the stakeholders the option to participate to the extent they felt able. Besides attending quarterly stakeholder meetings, some of the other tasks they were able to help with were contracting connections, access to training opportunities and facilitating meetings with other potential stakeholders not yet involved.

Our stakeholders were representatives from some of the following organizations:

- Billing Clearinghouse Representatives
- Health Insurance Exchange
- Health Insurance Plans
- Immunization Registry
- Local Billing and Practice Management Company
- Local Health Department Immunization Managers
- Medicaid Representative
- Nevada State Immunization Coalition
- Senator Harry Reid's office
- State Health Commissioner's Office
- State Health Information Technology
- State Immunization Program
- State Office of Minority Health
- State Public Health Foundation
- Vaccine Manufacturer Representatives

With this robust group, it was understood that not all would be participating or even attending every meeting, but the Nevada billing project team decided to continue to invite all on the initial list unless they chose to opt out.

The following is an overview, some excerpts and lessons learned from each of our stakeholder meetings.

March 2012 Meeting

Stakeholders met on March 20, 2012, at the Gold Dust West from 10:00 a.m.–2:00 p.m. for the initial meeting to be informed about the grant-funded project to develop a strategic plan to strengthen immunization billing infrastructure in Nevada’s public health departments. The first two hours consisted of presentations by:



Captain Duane Kilgus, MPH, RS, Health Education Specialist – The Centers for Disease Control and Prevention: *“Billing – What’s it all about?”*

Erin Seward, Immunization Program Manager – Nevada State Health Division:
“The State of Our State – Creating the Plan to Implement Billing in Nevada Health Departments”

Kathi Haynie, LPN, Project Coordinator – Carson City Health and Human Services:
“Nevada – What Lies Ahead”

Amanda Harris, Manager, Nevada WebIZ:
“Nevada WebIZ – Our Statewide Immunization Registry”

Jennifer Tinney, Program Manager – The Arizona Partnership for Immunization:
“Great News! We are billing for Administration Fees.”

After lunch, a breakout round table discussion was held with representatives from Nevada’s local health departments, insurance companies, and pharmaceutical companies, billing clearinghouse representatives, the Nevada State Health Division, Northern Nevada Immunization Coalition, Southern Nevada Immunization Coalition, Nevada Public Health Foundation, Nevada Healthcare Coalition, Carson City School District, and the Regional Representative for United States Senator Harry Reid. It was felt by all that this, our first stakeholder meeting, was a huge success.



The following are some of the questions and responses gathered from those interesting discussions:

1. What could your organization do to help make this project a success?

- Offer training on coding (for Medicaid) and assist with contracting issues (from some of the private insurance representatives)
- Offer assistance by sharing lessons learned (from the Arizona Coalition)

2. Name at least one potential barrier, and if possible a way to break through it.

(Interestingly enough, in retrospect many of these barriers have actually been faced during the project)

- May have difficulty contracting secondary to public health not being a 'standard healthcare model'
- The cost of purchasing private vaccine can be prohibitive
- The cost of implementation (i.e., having to purchase an EMR, contract with a clearinghouse, and so on)
- The local Primary Care Physicians perceiving public health as competition
- Complication of existing infrastructure

3. Name at least one person or agency that is not represented here that may be an advocate for this project.

- Affordable Care Act (Governmental Representative)
- Private Billers
- American Association of Pediatrics Representative
- Employer Groups
- Legislative Representatives

July 2012 Webinar

On July 9, 2012, the project team decided to hold a webinar style presentation rather than an in-person meeting. Eighteen stakeholder sites called in to participate. Some of the topics discussed were:

- Overview of the project
- Results of the client surveys for each health district
- Overview of the Affordable Care Act
- Introduction of the Nevada PH billing forum <http://phbilling-nv.proboards.com>

The billing project team realizes that the first stakeholder meeting attendance was much larger because it was the introduction and that there would be those that would not continue to come to all meetings. In addition to this normal attrition, there were many people away on summer vacation.

October 2012 Meeting

On October 11, 2012, the team held the third stakeholder meeting, choosing to return to the face-to-face format. This meeting was held in Las Vegas and was hosted by Pam Beal and the Immunization Coalition of Southern Nevada. Again we chose to have speakers on some of the topics that stakeholders had previously expressed interest in. The following is a synopsis of that meeting.

<u>Speakers</u>	<u>Topics</u>
Susan Pintar, MD, FAAP	ACA – How Will It Affect Public Health?
Jon Hager, Executive Director	Silver State Health Insurance Exchange
Kathi Haynie, Project Coordinator	Project Update/Overview of Pilot Projects

There were 36 attendees to this stakeholder meeting. The information presented by the guest speakers prompted many in attendance to suggest a format adjustment to allow more time for a roundtable discussion. Comment cards returned also showed interested private insurers asking to contract. Another success! *We chose not to hold a stakeholder meeting during the holidays; in January the public health departments were very busy with an influenza outbreak.*

March 2013 Meeting

On March 7, 2013, we held a face-to-face meeting in Las Vegas where 33 people attended. This meeting's format was adjusted to accommodate the requests of the stakeholders, so we provided a couple of brief presentations, allowing more time for roundtable discussions.

Nar Ramkissoon from UPP Technology reviewed the CCHHS Pilot Project Analysis from a financial return on investment standpoint and Kathi Haynie spoke to the process evaluation piece. (*See the Pilot Project section to view those results*). Patricia Iorizzo, the consultant from UPP technology who was contracted to manage the Southern Nevada Health District Pilot Project, was introduced and she gave a brief overview of her plans to work with them.

After these presentations, a dynamic roundtable discussion ensued. Here are some of the questions posed and the resultant discussions.

How do we prevent providers from thinking our clinics are trying to take their patients away?

- ❖ Create a partnership with primary care physicians.
- ❖ Have the health departments provide clients with referrals to a medical home.
- ❖ Immunize Nevada has not experienced any complaints from primary care providers; they have been pretty collaborative.
- ❖ Make a note / disclaimer: "This is not to take your patients."
- ❖ Explain that it's "not about how much money were going to make, it's about keeping the doors open and providing to those who need it."

What billing questions or issues would you like more information on?

- ❖ How to handle dual coverage clients

What process changes or alterations can be made now to accommodate the anticipated influx of Medicaid patients with the Affordable Care Act?

- ❖ SNHD said they are currently experiencing an influx as more providers are referring people to the health department.
- ❖ Training of staff will be important (i.e., eligibility checks)

How do we market / advertise that we are contracted with insurances?

- ❖ Post on health department websites
- ❖ CCHHS shared experience of marketing on/ in JAC buses in the Carson area (meets the target demographic appropriately)

This format proved to be the most successful, allowing for more brainstorming and problem-solving. The billing project team asked the stakeholders to complete a short survey in order to get feedback as to how to proceed with stakeholder meetings. (*See Survey in Resource section*).

September 2013

The next quarterly meeting would have been in July; however, the CDC had scheduled a National Immunization billing Stakeholder meeting in August, so it was decided to postpone Nevada's until afterwards in order to be able to share the information gleaned from the National meeting. When the stakeholders met again the roundtable discussion format was chosen based on the feedback from the survey. There were twenty-three attendees with the following presentations:

- Pilot Project Reports from CCHHS and SNHD
- A presentation from a representative from the health insurance exchange, Nevada Health Link
- Roundtable discussions of successes, barriers and solutions

Also, at this meeting the representatives from the Local Health Departments were given a survey to ascertain their level of training needs.

The next stakeholder meeting was not held due to the Holiday season. Subsequent stakeholder meetings would be dependent on the completion of the billing resource manual, with a target completion date of June 2014.

1.4.3 Local Health Department Analysis

At the beginning of the grant project in February 2012, each health authority in the State of Nevada (Carson City Health and Human Services, Southern Nevada Health District, Washoe County Health District, and the State of Nevada – Community Health Nursing Clinics) was asked to complete an online survey in order to gain perspective on their current billing practices.

The following questions were asked:

1. Do you use an Electronic Medical Record system (EMR)? If so, which one?
2. What is the total number of vaccine doses administered in 2011 at your facility for:
 - Children 0-18 Years
 - Adults 19-99 Years
3. Do you currently collect patient's insurance information in any capacity?
4. Which method do you use to collect patient's insurance information?
 - EMR, Paper, Registry, Other?
5. Please estimate the number of patients represented by the following categories in 2011:
 - Uninsured
 - Medicare
 - Medicaid
 - United Healthcare /Sierra / HPN
 - HHP
 - Blue Cross Blue Shield
 - St. Mary's
 - Cigna
 - Humana
 - Other
 - Unknown
6. Do you currently bill for immunization services?
7. How do you rate your current billing procedures?
8. What insurances do you currently bill?
9. Are you contracted with any insurance companies?
10. How do you submit claims? Check all that apply:
 - Paper
 - Roster Billing
 - Electronic (using a Clearinghouse)
 - Electronic (w/o a Clearinghouse)
 - Third Party Billing Company
 - Other
11. Do you receive any reimbursements for the following? Check all that apply:
 - None
 - All vaccines
 - Some vaccines
 - Administration Fee
12. Please estimate the average percentage rate of reimbursement you receive (i.e., amount reimbursed divided by amount billed)
13. On average, how long does it take your office to get reimbursed from the time of claim submission?
14. What are some major obstacles you may have encountered when securing reimbursements from public or commercial insurers?
15. What is the average time per week staff spends on billing for immunization services?

We learned that each health department was doing something a little bit different. Some were billing Medicaid and Medicare Part D only, a few private insurances were being billed by only two health departments, and one wasn't billing at all. The following table is a brief overview of what each health department's billing practices was in Nevada, as of January 2012 (the beginning of the project).

Washoe County Health Department	NV State Health Division Community Health Nursing
<p>Electronic Medical Record: <i>Insight</i></p> <p>Total Does of Vaccines Administered in 2011: <i>16,511 Children 0-18; 2,468 Adults</i></p> <p>Methods used to collect patient information: <i>Electronic Medical Records and Paper</i></p> <p>Estimate the Number of Patients Represented by the following categories: <i>Medicare 20; Medicaid 838; Unknown 5,680.</i></p> <p>Insurances Currently Being Billed / Contracted: <i>Medicaid</i></p> <p>Methods of Submitting Claims: <i>Electronic (w/o a clearinghouse) and roster billing.</i></p> <p>Average percentage rate of reimbursement: <i>40%</i></p> <p>Receiving Reimbursements for: <i>Administration Fee</i></p> <p>Time Spent on Billing: <i>12-20 hrs./week</i></p> <p>FTEs Used for Billing: <i>1 PT</i></p> <p>Time of Reimbursement: <i>5-6 weeks</i></p> <p>Some Major Obstacles in Securing Reimbursement from Public or Commercial Insurers: <i>Not contracted, not listed in the provider directory, don't have trained/experienced staff, missing charges or getting denials data entry errors.</i></p>	<p>Electronic Medical Record: <i>Lytec</i></p> <p>Total Does of Vaccines Administered in 2011: <i>14,477 Children 0-18; 430 Adults</i></p> <p>Methods used to collect patient information: <i>Electronic Medical Records, Registry</i></p> <p>Estimate the Number of Patients Represented by the following categories: <i>Medicaid 2,083; Uninsured, Medicare and unknown not reported</i></p> <p>Insurances Currently Being Billed / Contracted: <i>Medicaid, Medicare, BCBS</i></p> <p>Methods of Submitting Claims: <i>Electronic using a clearinghouse (ZirMed)</i></p> <p>Average percentage rate of reimbursement: <i>43%</i></p> <p>Receives Reimbursements for: <i>Administration Fee, Some Vaccines</i></p> <p>Time Spent on Billing: <i>11-20 hours per week.</i></p> <p>FTEs Used for Billing: <i>3</i></p> <p>Time of Reimbursement: <i>3-4 weeks</i></p> <p>Some Major Obstacles in Securing Reimbursement from Public or Commercial Insurers: <i>Not contracted</i></p>

Carson City Health and Human Services	Southern Nevada Health District
<p>Electronic Medical Record: <i>eClinical Works</i></p> <p>Total Does of Vaccines Administered in 2011: <i>4,899 Children 0-18; 3,637 Adults</i></p> <p>Methods used to collect patient information: <i>Electronic Medical Records, Paper, Registry</i></p> <p>Estimate the Number of Patients Represented by the following categories: <i>Uninsured 2,131; Medicare 979; Medicaid 1,124; United Healthcare/ Sierra Health Services/HPN 0; HHP 0; BCBS 193; St. Mary's 72; Cigna 0; Humana 0; Other 55; Unknown 6.</i></p> <p>Insurances Currently Being Billed / Contracted: <i>Medicaid, Medicare, BCBS and St. Mary's</i></p> <p>Methods of Submitting Claims: <i>Paper, Electronic (using a clearinghouse), third party billing to submit claims (Physician Select Management).</i></p> <p>Average percentage rate of reimbursement: <i>45%</i></p> <p>Receives Reimbursements for: <i>Vaccines, administration fees and other services</i></p> <p>Time Spent on Billing: <i>Less than 10 hours per week</i></p> <p>FTEs Used for Billing: <i>2</i></p> <p>Time of Reimbursement: <i>3-4 weeks</i></p> <p>Some Major Obstacles in Securing Reimbursement from Public or Commercial Insurers: <i>Not contracted, missing charges or getting denials because of staff data entry.</i></p>	<p>Electronic Medical Record: <i>WebIZ</i></p> <p>Total Does of Vaccines Administered in 2011: <i>152,889 Children 0-18; 22,788 Adults</i></p> <p>Methods used to collect patient information: <i>Electronic Medical Records, Paper, Registry</i></p> <p>Estimate the Number of Patients Represented by the following categories: <i>Uninsured 29,640; Medicare 1,439; Medicaid 10,125; United Healthcare/ Sierra Health Services/HPN 183; Other (Culinary) 10,369; Unknown 24,046</i></p> <p>Insurances Currently Being Billed / Contracted: <i>Medicaid, Medicare, United Healthcare/ Sierra Health Services/HPN, and Culinary</i></p> <p>Methods of Submitting Claims: <i>Paper, Electronic (w/o a clearinghouse), roster billing, and bill through an internal finance department.</i></p> <p>Average percentage rate of reimbursement: <i>81%</i></p> <p>Receives Reimbursements for: <i>Administration Fee, Some Vaccines, Healthy Kids Exam, Family Planning</i></p> <p>Time Spent on Billing: <i>More than 40 hours per week.</i></p> <p>FTEs Used for Billing: <i>3.2</i></p> <p>Time of Reimbursement: <i>11-12 weeks</i></p> <p>Some Major Obstacles in Securing Reimbursement from Public or Commercial Insurers: <i>Not contracted, not listed in the provider directory, don't have trained/experienced staff, missing charges or getting denials because of data entry errors, reimbursement too low</i></p>

The next step in the process was to find out what type of clients were seeking services at the public health departments in Nevada; were they, uninsured, underinsured or insured, and if so, what was their awareness level of their insurance type and status? To determine this information, the following questionnaire was given to all clients seeking immunization services from March through April 2012 and was provided in both English and Spanish, along with a FAQ sheet to assist the administrative assistants with answering potential questions.

Public Health Department Client Questionnaire

In order to better serve you, we are conducting a short survey. Please answer **all** questions to the best of your ability.

1. Age(s) of person(s) being seen today: _____
2. Ethnicity: Hispanic or Latino Not Hispanic or Latino Other
3. Zip Code: _____
4. Do you have (check one): Medicaid Medicare Nevada Check Up
 Other _____ No Insurance **IF NO INSURANCE, STOP
HERE**
5. Does your insurance cover vaccines? Yes No I don't know
6. Do you have a co-payment? Yes No I don't know
7. If you have a co-payment, how much is it? \$ _____
8. Who is the Employer for the person who has the insurance?

9. What is the group number of your insurance? _____ I don't know
10. What is the purpose of your visit today? Immunizations Other

Over 6300 questionnaires were returned from the public health departments' clients all over the state of Nevada. The results of these questionnaires were shared at the July 2012 stakeholder meeting and a formal report was given to all. The following are the summaries from each department/district.

Demographic Results

The following demographic tables represent client’s responses. It is important to note that many clients chose not to answer the ethnicity question.

AGE	Southern Nevada	Carson City	Washoe	CHN (State)
0-10	40.5%	16%	36%	37.7%
11-18	24.6%	12%	16%	20.1%
19-30	15.1%	40.7%	27.7%	23.8%
31-45	11.5%	19%	14%	13.3%
46-65	6.6%	10.8%	6%	3.9%
65+	1.7%	1.5%	0%	1.2%

ETHNICITY	Southern Nevada	Carson City	Washoe	CHN (State)
Hispanic	40.6%	37.8%	27.4%	32.3%
Not Hispanic	28.9%	50.6%	29.2%	50%
Other	30.5%	11.6%	1%	17.8%

Private Insurances Seen

The following private payers are listed in the order that were most prevalently seen in each health department.

Southern Nevada	Carson City	Washoe	CHN (State)
UHC BCBS Culinary Health Plan of NV Teacher’s Health Clark County PEBP (State of NV Self-funded) Cigna Aetna TRICARE	BCBS Saint Mary’s Nevada Check Up NV State PEBP Hometown Health HHP	Health Plan of NV Amerigroup BCBS HHP United Healthcare	BCBS Cigna Nevada Check Up TRICARE

Carson City Health and Human Services (CCHHS)

CCHHS had been billing Medicaid, Blue Cross Blue Shield and St. Mary's for all services since 2006 using an outsourced billing agency. This survey confirmed that the majority (over 60%) of Carson and Douglas County clients are uninsured. Of those that hold insurance, over 60% have some sort of subsidized health insurance (i.e., Medicaid, Women's Health Connection or Medicare).

Since they had the capability to compare data entered in the electronic medical record, a comparison was done to check the accuracy of the data collected. The results were that 55% of the clients seen (and entered into the EMR) completed a survey. The actual breakdown of the insurance payer mix reflected that there were more with Blue Cross Blue Shield (15% in the EMR vs. 8%) and less with St. Mary's Health Insurance (4% vs. 6%). Also of note was the percentage of Women's Health Connection patients that was 21% in the electronic medical record versus only 2% completed the survey. These discrepancies should be taken into account when evaluating the outcome of this survey.

One of the goals of this survey was to determine the top five private insurers of clients seen at Carson City and Douglas County Community Health Clinics. The top five private insurances seen were Blue Cross Blue Shield, St. Mary's, Hometown Health Plan, State of Nevada Public Employee Benefit Plan and Cigna.

State of Nevada Community Health Nursing

The client questionnaires returned reflected and confirmed what was expected as far as the classification of the different status of insurers. The client questionnaires given in the months of March-April 2012 reflected 55% uninsured, 41% Public (including Medicaid, Medicare and NV Check Up) and 4% private insurers. The top five insurers for the Community Rural Health Clinics are: Blue Cross Blue Shield, Cigna, Hometown Health Plan, Aetna and Principal Life.

Southern Nevada Health District

Our initial questionnaire given to the Immunization Clinic Department Managers reported a total in 2011 of 29,640 (39%) of clients who had no insurance; 10,125 (13%) had Medicaid; 10,369 (13%) had Culinary Insurance; and 24,046 (31%) were reported as unknown. The remaining 4% were represented by United Healthcare, Health Plan of Nevada and Medicare.

The client questionnaires reflected 62% uninsured, 24% Public (including Medicaid, Medicare and NV Check Up) and 14% private insurers.

With the implementation of the Affordable Care Act, it is estimated that there will be at least a 12% drop in the uninsured rate, moving those clients into either a public (Medicaid, NV Check Up or similar

subsidized program) or private insurance group. Based on the information gathered in this survey, this will increase the number of insured clients seeking care at Southern Nevada Health Departments by 6,442. Their top insurers were Blue Cross Blue Shield, United Healthcare, Cigna, Aetna and Culinary. Since Culinary already has a contract, it may be beneficial to review and possibly amend that contract in order to better serve their more than 125,000 clients.

Washoe County Health District

Washoe County Health district opted out of distributing the client questionnaires and instead chose to query their electronic medical records for the data. The clients seen at the Washoe County Health Immunization Clinic were not dissimilar to those in the insurance groups seen at the other health department clinics in the state, with the exception of the Medicaid Managed Care organization Amerigroup, which represented 39%. There were 24% regular Medicaid and only 12% privately insured. It is important to note that the uninsured population is an assumption due to the fact that some do not choose to reveal they have insurance.

To Pilot or Not to Pilot?

Once the client demographic and insurance status of all clinics was established, options were given to the health departments to participate in pilot projects. Since the concept of billing was sometimes overwhelming and daunting at best, the approach of a tier system to ease into billing was introduced. This tier system would allow for graduated incremental billing at the pace the health department decided to go. The following table describes the tiers.

PUBLIC HEALTH BILLING	Tier 1	Tier 2	Tier 3
	Medicaid (Managed Care, FFS, HMO)	Medicare Part B and Part D	Private Insurance
<i>Phase 1</i>	Immunizations	Immunizations	Immunizations
<i>Phase 2</i>	Family Planning	Family Planning	Family Planning
<i>Phase 3</i>	Well Child	Well Child	Well Child
<i>Phase 4</i>	Outreach (Employers/Schools)	Outreach (Employers/Schools)	Outreach (Employers/Schools)

CCHHS agreed to participate as a pilot project with the main goal of comparing the sustainability and cost effectiveness of having an internal biller versus their past experience of having outsourced billing. The goals and scope of work are demonstrated on the following pages.

1.5 Pilot Projects

1.5.1 Carson City and Douglas County Community Health Clinics Pilot Project

Background

Carson City Health and Human Services (CCHHS) had been billing for immunizations and other clinic services since 2006, utilizing an outsourced billing company. This contract was up for renewal on June 30, 2012, and CCHHS chose not to renew the contract. There are variable methods of billing, including employing a billing service or an internal biller. CCHHS expressed an interest in being a pilot in this billing project and chose the option to hire a (temporary) internal biller. The term for this pilot was six months and the goal was to compare it to other pilot projects to evaluate effectiveness of processes, improvement in revenue and, ultimately, overall return on investment. The success of this pilot will be measured by meeting the following objectives:

- I. Reimbursements from private insurers other than St. Mary's and Blue Cross Blue Shield (currently contracted with)
- II. To increase overall reimbursements by closer follow-up on outstanding accounts receivable (A/R)
- III. To improve access to healthcare options by contracting with more insurers and advising local employers of the option to seek care at public health clinics
- IV. To maximize billable collections by setting quality improvement guidelines for follow-up
- V. To decrease coding and posting errors by providing training to staff
- VI. To assure consistency and fairness of practices by reviewing and rewriting (if indicated) policies and procedures for billing
- VII. To complete a written plan for conversion to ICD-10 diagnosis codes

Objective 1) Demonstrate expansion of revenue streams from increased Private Payers		
Activities	Outcome, Documents, Reports	Timeline
Letters to be sent to top five payers (not currently contracted with)	Follow up report documenting outcome of outreach attempts	July 2012
Contract with above identified insurers (as possible)	Signed contracts	Sept. 2012
Create a financial analysis report to evaluate revenue	Financial analysis report	Dec. 2012

Objective 2) Increase overall reimbursements by closely following outstanding balances		
Activities	Outcome, Documents, Reports	Timeline
Identify the top three issues contributing to large accounts receivable balances	Report of issues	Aug. 2012
Contact Insurers to follow up on reasons for non-payments	Summary of findings will contribute to education of staff	Aug. 2012
Re-submit claims as indicated	Report of claims resubmitted and results	Oct. 2012
Create a report on accounts receivable (A.R.)	Show improvement on outstanding balances in 61-90 and 91-120 days A/R	Dec. 2012

Objective 3) Improve access to healthcare by contracting with more Insurers and notifying local employers

Activities	Outcome, Documents, Reports	Timeline
Contract for at least Immunization services with top five local payers	Matrix of all contracts (by service types)	Nov. 2012
Send letters to locally impacted employers	Sample letter	Nov 2012

Objective 4) Create and institute billing quality assurance measures

Activities	Outcome, Documents, Reports	Timeline
Run production claims report from eClinical Works and compare with Gateway report	Done weekly with a quarterly summary of issues found	Oct. 2012
Run weekly patient statement reports to ensure invoice correct	Done weekly with end of month report given to accounting	Ongoing

Objective 5) Provide training to staff in order to decrease coding and posting errors

Activities	Goal/Documentation	Timeline
Provide quarterly coding updates	Sign In sheets from staff meetings	Oct. 2012
Create a training manual as a resource for staff	Training manual	Dec. 2013

Objective 6) Update billing policy and procedures for the following:

Activities	Goal/Documentation	Timeline
To address donations/overpayments from self-pay 'tiered' patients	P & P reviewed and accepted by clinic manager	Aug. 2012
To address doing 'soft' collection calls	P & P reviewed and accepted by clinic manager	Aug 2012
Returned mail	P & P reviewed and accepted by clinic manager	July 2012
Month end processes	P & P reviewed and accepted by clinic manager	Aug 2012
Write off adjustments	P & P reviewed and accepted by clinic manager	Sept 2012
Accounts receivable reports	P & P reviewed and accepted by clinic manager	Sept. 2012

Objective 7) Prepare for ICD-10 transition (October 2014)

Activities	Goal/Documentation	Timeline
Provide training to staff with top codes affected and support documentation needed	Training Manual	Dec 2013
Complete a written plan for ICD-10 transition	To be reviewed and approved by clinic management as well as electronic medical record vendor to determine feasibility	Dec 2013

At the end of the six-month period, a financial analysis was performed by a consultant from UPP technology. The goal of this analysis was to compare an internal biller versus using an outsourced billing agency. The following is their report.

Comparative Financial Analysis

It is evident that these two billing models are different in structure, operational requirements, and net revenues. To compare both types of billing programs at CCHHS, certain assumptions were made that standardized the environment for both FY12 and FY13. Selecting the July-December timeframe standardized seasonality, while adding the expense of nurse practitioners and the EHR fees provided a better estimate of true costs in implementing an in-house program. By using revenue and expense metrics in the analysis, CCHHS can determine the effectiveness of both billing programs, as well as the impact of the transition to an in-house model for pilot purposes.

In comparing the two models, there was an increase in total revenue (adjusting for Medicaid and Outreach) of \$5,115.23, or a 3% increase in revenue after transitioning to the in-house model. Billing expenses, specifically the PSM fees and the costs of a billing specialist, EHR, and nurse practitioner, increased by \$1,503.00, or 2%. However, when including clinic and immunization expenses, total expenses increased by \$10,426.86, or 9%. That represents a significant change, but again can be attributed to the increased vaccine expenses.

Overall, there was a 16% net decrease in revenue, or \$5,311.63, incurred in the transition from the outsourced model to the in-house model, even though total revenues actually increased slightly. Though this data is reflective of a sample time, the operational implications should be discussed with the potential long-term sustainability of programs in mind.

Pilot Analysis: Change in Net Revenue from FY12- FY13					
	FY12	FY13	Δ	% change	
Base Revenue	\$ 181,682.26	\$ 190,994.36	\$ 9,312.10	5%	
MCD	\$ (12,405.93)	\$ -	\$ -	-	
Outreach	\$ (21,671.19)	\$ (38,273.99)	\$ -	-	
Total Revenue	\$ 147,605.14	\$ 152,720.37	\$ 5,115.23	3%	
Expenses					
PSM/Billing Person	\$ 77,490.00	\$ 26,567.00	\$ 50,923.00	-66%	
Hosting/Support	\$ -	\$ 2,575.00			
Nurse Practitioners	\$ -	\$ 49,851.00			
Total Billing Expenses	\$ 77,490.00	\$ 78,993.00	\$ 1,503.00	2%	
Total Expenses	\$ 114,889.57	\$ 125,316.43	\$ 10,426.86	9%	
Net Gains	\$ 32,715.57	\$ 27,403.94	\$ 5,311.63	-16%	

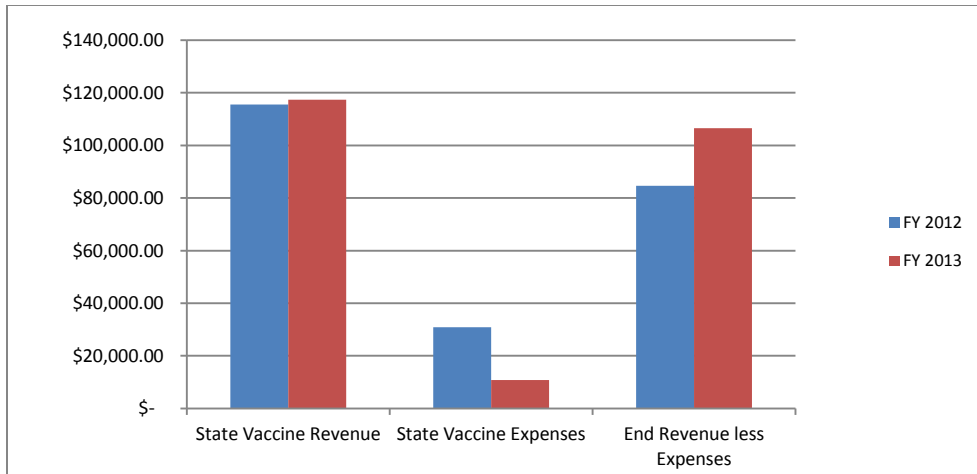
Source: UPP Technology Analyst Report March 1, 2013

Another important factor is that during this time Carson City Health considerably increased their community flu outreach events to include a significant amount of insurance billing, even collaborating with the School-Located Vaccine Program, billing at schools for the first time. Also, it is important to note that this was NOT a cost-effectiveness analysis for billing but rather a comparison of internal vs. outsourced billing. The choice of CCHHS to employ the Nurse Practitioners significantly impacted the expenses. Due to these additional expenses, it was felt that further revenue analysis would prove beneficial in order to determine sustainability of this billing project. Thus the pilot project at CCHHS was extended. The following tables show that with more training there was increased overall revenue.

CCHHS State Vaccines Revenue Comparison

Calendar Year	State Vaccine Revenue	State Vaccine Expenses	End Revenue less Expenses
2012	\$115,567.69	\$30,897.16	\$84,670.53
2013	\$117,364.69	\$10,830.68	\$106,534.01

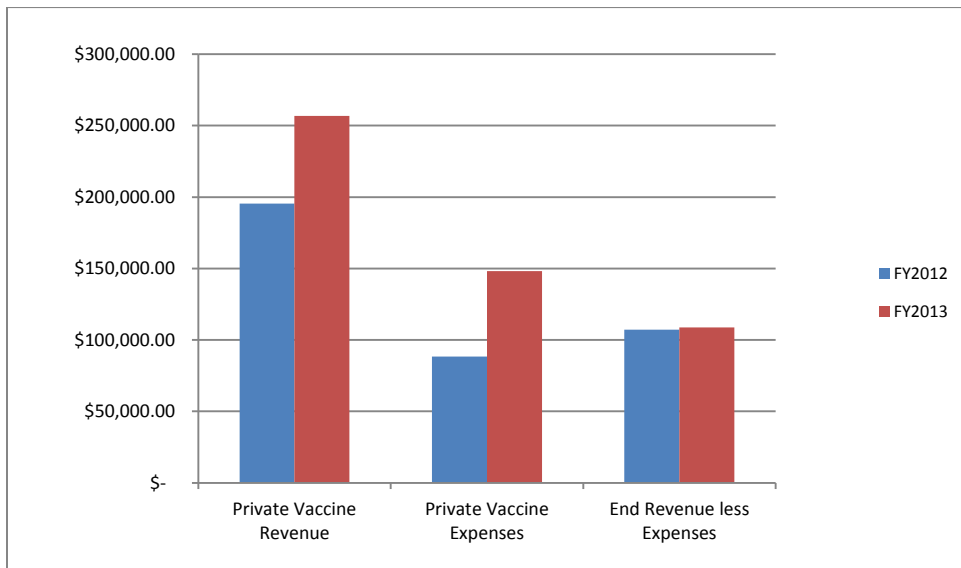
The increase in overall revenue of \$21,863.48 in 2013 for State Vaccine was largely due to more efficient billing of administration fees for VFC vaccine.



CCHHS Private Vaccines Revenue Comparison

Calendar Year	Private Vaccine Revenue	Private Vaccine Expenses	End Revenue less Expenses
2012	\$195,472.12	\$88,270.82	\$107,202.30
2013	\$256,823.96	\$148,187.90	\$108,646.06

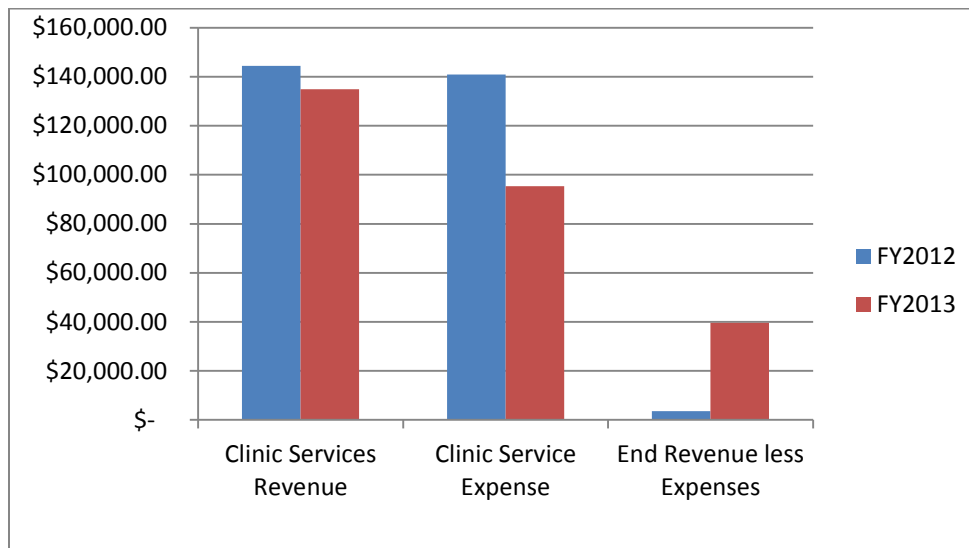
The resulting revenue increase of only \$7923.76 is misleading due to the increased expenses of \$59,917.06. The increased revenue allowed for the clinic staff to attend trainings and expand their education and supplies in order to make the program sustainable.



CCHHS Clinic Services Revenue Comparison

	Clinic Services Revenue	Clinic Service Expense	End Revenue less Expenses
2012	\$144,472.53	\$140,901.51	\$3,571.02
2013	\$134,965.40	\$95,313.44	\$39,651.96

This increased revenue of \$36,080.94 for billing of clinic services is completely attributable to private insurance billing successes.



In addition to the overall revenue increase, there was a significant increase in the community influenza outreach events that were billed. In the past, CCHHS had billed one private insurance, plus Medicare and Medicaid, and in 2013 they billed all contracted insurances. The following table shows the revenue successes seen in this area which are imperative to include when considering the sustainability of billing in public health.

Community Vaccination Events					
Revenue	FY12	FY13	Δ	% Change	
Schools	\$ -	\$ 8,511.00	\$ 8,511.00	N/A	
Employers	\$ 11,495.00	\$ 15,420.00	\$ 3,925.00	34%	
Others	\$ 10,176.19	\$ 14,342.99	\$ 4,166.80	41%	
Total	\$ 21,671.19	\$ 38,273.99	\$ 16,602.80	77%	

Several key factors need to be considered when coming to a conclusion about the sustainability of insurance billing and specifically having an internal biller versus outsourcing billing and some of those are:

- Ease of staff reaching and communicating with the biller (when that person is on premises)
- Routine attendance at clinic staff meetings for education and updates
- Often more buy-in since they are employed by the organization
- Having someone who can come out and speak with a client and explain their bill, if needed

1.5.2 Southern Nevada Health District

In January of 2013, the Southern Nevada Health District agreed to participate in a pilot project utilizing a consultant from UPP technology, Patricia Iorizzo. The project charter below is her work plan for that pilot.

Project Title:	<i>Paying for Immunizations: The Role of a Private-Public Relationship</i>
Brief Project Description:	Immunization programs should be a shared public-private partnership
Project Objective:	
<p>Foster multi-sector partnerships and coalitions to broaden access, reimbursement and awareness.</p> <ul style="list-style-type: none"> • Changing payment and delivery models will provide further incentives to vaccinate recommended populations. • Quality assurance • Provider education • Immunization rates are higher for persons with insurance*more people will enter the insurance system in 2014. • Responding to protect public health • Increase our community wide effort to focus on gap areas, resources, and energy and common goals for immunizations. <p><small>*Cotter J. Napa Immunization Study: Immunization Rates for Children with Publicly Funded Insurance Compared with Those with Private Health Insurance in a Suburban Medical Office. 2011. The Permanente Journal, v. 15:4</small></p>	
Assumptions	
<p>Vaccines for Children Program (VFC)</p> <ul style="list-style-type: none"> • Created by the 1993 Omnibus Budget Reconciliation Act, operational since October 1994 • Eligible children (through 18 years of age): Medicaid eligible, uninsured, American Indian/Alaska native, underinsured in Federally-Qualified Health Centers or Rural Health Centers • Legislation gives the Advisory Committee on Immunization Practices the authority to determine the vaccines that will be provided in the VFC Program • VFC is a federal entitlement program 	

Insurance Coverage for Immunization Services (before the Affordable Care Act)

- Failure to seek reimbursement for services rendered results in missed opportunities to generate significant revenue – money that could be used to finance and enhance vital immunization programs for children and adults
- Most private health insurance includes coverage for routine immunizations
- Insurance plans may not cover entire cost of vaccine or office visit (a co-pay may be required)
- A deductible may need to be met before the costs of immunizations are covered by the plan
- As the new plans are written and existing plans lose their grandfathered status, the number of underinsured children and adults will begin to decrease

Project Scope

- Develop an action plan that will describe activities, protocols, and procedures needed to pilot, initiate, and sustain a successful billing effort within the immunization program.
- New health insurance plans must provide coverage for ACIP recommended vaccines without deductibles or co-pays, when delivered by an in-network provider
- Evidence-informed preventative care and screening for women, children and adolescents as guided by the HRSA (Health Resources and Services Administration)
- Although some uncertainties around the ACA remain, with full implementation over the next several years expectations are that the problem of the underinsured should largely be solved.
- Utilizing AHIP presentations and webinar sessions for best practices, review various claim submission mechanisms and credentialing requirements for public health agencies providing vaccines @<http://www.ahip.org/Archived-Webinars-Immunizations/>

Exclusions from the scope.

1. Long before the ACA, health plans have been committed to promoting recommended vaccines in all populations, and were supportive of the ACA provisions that all new health plans are required to provide first dollar coverage for all ACIP recommended routine vaccines.
2. High deductible health plans have typically provided first dollar coverage
3. Plans often reimburse non-traditional providers such as pharmacies, retail clinics, etc. to increase accessibility and vaccination rates.

The results of this pilot were affected by several factors, some of those factors were:

- Change in administration, both the Chief Health Officer (who would have to approve all contracts) and the head of administration
- Lack of current cost analysis and up-to-date fee schedules
- Current 'climate' surrounding a physician's perception that SNHD was trying to compete with the local private providers unfairly by purchasing vaccines for a reduced price and selling them to make a profit (travel vaccines)
- Reluctance to address the above perceptions in the community
- Much of the financial and staff resources were being expended towards the purchase of an Electronic Medical Records system

It is for the above reasons that many of the goals set forth by this forward thinking project charter did not come to fruition. In 2014, after the grant received a no-cost extension, the Southern Nevada Health District had a new administrator and Chief Health Officer and was successful in moving ahead with the billing project. At the time of this writing, they had developed their fee schedule for vaccines and the cost analysis for other services with the hope of creating fee schedules within the next few months. They had also been successful in garnering two new contracts for vaccine billing.

1.5.3 State of Nevada Community Health Nursing Clinics Billing Process Review

This report was compiled from observations of the billing process in place during several site visits over a three-month period in 2013-14. The goal of these visits was to evaluate current practices for efficiency, accuracy and reimbursement percentage. It is important to note that these visits were limited and only offered a snapshot overview of the billing process in place. The following observations and subsequent suggestions for best practices are based on my experience and knowledge of medical billing. Throughout the report I have indicated in *Italics* my suggestions.

Background

At the Division of Public and Behavioral Health, medical billing is done for 13 rural health clinics for both family planning and community health services. Some of these services include immunizations, sexually transmitted infection testing and treatment, birth control, school health, HIV and tuberculosis testing and child health wellness visits.

The clinics have an Electronic Medical Record (EMR) which has two components, a clinical and a billing module. These two components are currently not set up to communicate or interface with each other, which poses some significant and unique issues that I will discuss in detail in the observations summary.

Currently there are three billers that process claims for Medicaid, Blue Cross Blue Shield, Cigna, Medicare Part B, and St. Mary's and their Networks, which include more third party payers. They provide services on a sliding fee scale for those that have no insurance. This scale is based on percentage of the Federal Poverty Levels (which is set annually by the federal government).

Process

Clinic Level

At the clinic the healthcare providers, either Registered Nurses or Advanced Nurse Practitioners see the client and decide what codes to bill for. They then give this information to the administrative

assistant (at the front desk) who puts the information in the billing module of the EMR. *For efficiency and to decrease the possibility of data entry errors, these codes should be entered by the person who provided the services; however, the limitation of the system may not allow for this change. One way to work around this would be to include an internal audit review tool that checks for accuracy.*

After the client has been seen, they pay (if applicable) and the money collected is applied to the account in the EMR by the AA. If they are not already doing it, they should be showing the Title X clients what their bill would have been prior to the discount and what they owe, as this is a Title X requirement. In the case of a privately insured client, it is imperative to collect any applicable co-pays or deductibles at the time of visit, as once the client leaves your opportunity goes with them! This is an important change to the mind-set of many regarding public health equals cost-free health, both on the side of the patient and the staff. *You will need to teach your staff how to ask for co-pays in such a way that it is routine but friendly and just part of their daily process. Many clients will not know if they have a co-pay or, if so, how much. This information can usually be found on the client's insurance card. It is important to note that with the passage of the Patient Protection and Affordable Care Act, preventive care visits, including immunizations and pap smears, do not necessitate a co-pay, so educating your staff is crucial.*

Prior to the visit, if not currently practiced, you should have your staff do the following: 1) Call and remind patients of their appointments; 2) Remind them to bring their co-pay with them (if applicable); 3) Ask if any of their insurance information has changed; and 4) If feasible (not too busy) check client insurance eligibility prior to their visit (this should **always** be done for more costly visits, such as IUD insertions, etc.) Also, it gives the staff a chance to see if the service needs a prior authorization.

The administrative assistants are also responsible for sending patient statements of balances owed. These statements are sent monthly. *One suggestion is to investigate what your average payment percentage is from generating these statements. Compare that revenue against what it is costing to send the statements and then decide if the process needs to be changed.* Often practices do not think to look at current procedures and just continue with status quo even though those procedures are not gaining any revenue.

Billing Department

As mentioned in the introduction, the DPBH currently employs three full-time equivalents to do their billing. These employees consist of an accounting specialist and two administrative assistants. One of the AAs processes the claims from the EMR and sends them to the clearinghouse. This is done twice monthly on the 15th and 30th. *For more timely filing and thus quicker reimbursement, you might consider doing this once weekly. The most important issue I found was that no one was scrubbing the claims prior to submitting to the clearinghouse. Scrubbing claims includes examining the claims for accuracy of demographic information, coding and overall billing. This process helps decrease errors and is imperative in creating a clean claim. Also of importance is that, if audited, you will need to show the payer you are demonstrating due diligence in attempting to provide accurate claims.*

There is some scrubbing being done at the clearinghouse level, but that is only for very specific things, such as the Medicaid number has to be 11 digits. The person that is tasked with scrubbing the claims will have to have billing and coding education. This AA is also responsible for auto posting payments from the clearinghouse that come over electronically. She passes on the denials to the second AA.

The second AA is responsible for handling the denials and entering the non-electronic payments from the private insurances. This person passes claims that should not have been denied to the accounting assistant to investigate. *One suggestion is to make sure this AA has training to know what CPT codes should be billed with what ICD-9 (10) diagnosis codes and updates, as changes come out. This process should be less daunting if claims are scrubbed and submitted clean the first time.*

The accounting assistant has multiple responsibilities, which include researching and appealing unpaid claims, running accounts receivable reports, and communicating with the clinics regarding billing issues or questions. Much of the time she spends on denials, appeals, and overpayments could probably be cut in half by scrubbing the claims prior to sending them to the payers. Also, typically you spend \$14-\$25 for every claim you have to appeal.¹ She also catches accounts that need to be paid and reminds the clinics to send statements if not doing so.

Another aspect of the billing process was to examine whether reimbursements were in line with the contracted agreement with the payers. This report was run in the EMR but the results showed multiple units were billed for the same service or product on single patients. Follow-up is needed to

be able to ascertain the full reimbursement report, but when looking at individual codes on claims, the reimbursement was in line with that given to other public health clinics.

Best Practices Suggestions

In addition to the above noted suggestions, there are several best practices that should be in place.

Here are a few of the most important:

- Have written policies and procedures for all facets of your billing process, including a hardship policy, accounts receivable, statements, scrubbing claims and processing payments, to name a few.
- Institute a quality assurance tool that assesses all aspects of billing for accuracy, including charting, documentation supporting coding, correctness of data entry, HIPAA documents signed, billing acknowledgements signed (patient's agreeing to allow their insurance companies to pay you) and follow up with necessary training.
- Collect co-pays and deductibles at time of visit (where applicable).
- Offer a payment plan for outstanding balances.
- Offer ongoing education and training for staff.
- Ask staff if they are seeing new insurances (in order to seek out and contract with new insurances).
- Create cheat sheets for front office staff with sample insurance card copies.
- Create cheat sheets for clinical staff for coding assistance.

Summary

In summary, the billing process at the Nevada DPBH is multidimensional and multifaceted, but overall it gets the job done. There are always ways to improve and some of those suggestions noted above will help. The fact that there are so many private insurance options to clients coming to the community health clinics is quite an accomplishment and should be recognized, as such varied contracts generally do not exist at public health clinics across the country.

The Electronic Medical Record limitations with regard to the lack of interface between the clinical and fiscal creates a barrier to having a complete billing system, but the workaround in place gets the job done.

I cannot emphasize enough the importance of instituting a change to ensure the claims are submitted clean the first time, and that would be to examine the claims for accuracy prior to submittal. This would mean a change in day-to-day processes of the billing department staff, but the result should show a significant decrease in denials and appeals and subsequent increase in bottom line revenue.

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Section II. Billing 101

2.1 Planning and Preparation/Doing the Homework

It is vitally important that once you have decided to contract with insurances to bill for clinic services, you do your homework first. This section is an overview of what is needed before you can move forward with an effective and successful billing program.

Here is a brief step-by-step overview, with an in-depth description of how to do each step to follow.

- 1) Do a Cost Analysis to determine what it costs to provide services—what should your fees be?
- 2) From that Cost Analysis, create a fee schedule
 - a. Determine if you want to have a sliding (or adjustable according to income) fee schedule to accommodate those without insurance
 - b. Once fees are developed, take for approval to Boards of Health, Supervisors, Commissioners, or whatever authority needed for your jurisdiction
 - c. Publish your fees online (optional)
- 3) Survey clients to determine which insurances you need to contract with (optional)
- 4) Find out who the contracting specialists are for the insurances you wish to contract with (usually by calling the number on their website)
 - a. Send a Letter of Intent to contract
- 5) Work on credentialing the providers in your organization that you will be billing under
- 6) If you have an EMR, you will need to have someone input all the necessary billing numerical identifiers and decide if you will use a clearinghouse
- 7) If you do not have an EMR, you will need to decide if you want to purchase billing software and/or use a clearinghouse
- 8) You receive communications (usually in the form of a contract) from the insurance specialist, you will then need to look it over and pass it through the appropriate chain of command for your organization (i.e., administration, legal, etc.)
- 9) Once it is approved in legal and you sign it, the insurance contracting specialist will contact you with their specific credentialing requirements and you will need to comply (in as timely a manner as possible as this is the process that can take up to 90 days)
- 10) When the credentialing process is complete, the specialist will notify you of an effective date (when you can begin seeing and billing their clients) ***It is NOT necessary to have the final signed contract to be able to bill; it is industry standard that the e-mail or letter stating the effective date is sufficient.

2.1.1 Cost Analysis

Doing a cost analysis prior to setting your fees for services makes smart business sense; however, most public health departments have never thought of themselves as a business, so often they have fees that haven't changed for decades. When considering billing, you must think like a business, but it is important in public health to continue to maintain the goal of providing excellent healthcare to those in need.

There are several different methods of determining the cost of providing services, but public health officials must keep in mind that they cannot set the fees so high that their clients cannot afford to come to their clinics and also, so as not to compete with the private sector healthcare market.

The following methods are used most often to determine costs:

- Resource Based Relative Value Scale (RBRVS) – a tool developed by the American Medical Association which provides a numerical index that takes into consideration the geographical location, physician or provider specialty, overhead and other costs and gives a numerical value for the procedure*
- Usual and Customary (or Reasonable, Usual and Customary) – long used by the health insurance plans to describe what they pay the providers for a service
- Manual cost analysis – determine your overhead, what the provider's time is worth, supplies used and indirect costs (in public health this model often creates an inflated price structure)
- Medicaid/Medicare guidelines – determine your fee schedule based on what Medicaid and/or Medicare reimburses for the services you are rendering (this can often be much lower than what it actually costs to do business and what the private payers will reimburse)

*The American Medical Association website provides a thorough description and guidelines for use of the RBRVS: <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale.page>

2.1.2 Fee Schedules

Most public health departments with successful billing programs have used a combination of all the methods to develop their fee schedules. To accommodate the impoverished and uninsured population seeking services at public health clinics, many choose to create a sliding fee schedule which can be accomplished by reducing their standard fees in decrements of 25% 50%, 75% and 100% according to the Federal Poverty Level. This is a commonly accepted method by the Federal Title X program that provides funding to public health clinics for family planning services.



It is important to remember other funding sources, such as: tax dollars, grants, and state funds when doing your cost analysis!

2.1.3 Practice Management Software or Electronic Medical Records

Many public health departments do not have an electronic medical records (EMR) system; however, the majority of insurances are moving towards receiving and transmitting all claims electronically, so it will be important to consider an EMR when looking towards the future of billing.

The first and probably most important thing to consider when deciding on an Electronic Medical Record (EMR) is what are my needs? When you begin searching for an EMR or Practice Management software, you will need to determine how your current processes work and how flexible you are if the software works a bit differently. The software should have simple functions, such as the ability to maintain appointments, Progress Notes and Claims Billing options.

The software often offers useful canned reports to use for your month end, year-end and production goals. Some software gives the clinic the option to create custom reports for your business needs for an additional fee.

As public health, we understand that funding can be cost-prohibitive due to budgetary limitations, so you will need to consider this as well when looking for a product. Be sure that the benefits of using software will make your processes more efficient and more detailed. Using an EMR allows you to bill your claims electronically, which lessens the turnaround time for reimbursement.

EMR Set-Up

Once you have chosen an EMR, you will need to have it customized to accommodate your clinic's individual needs, including your billable codes, fee schedules and, of course, your providers' information. There are many codes to understand in billing and the next section will be an overview of those codes.

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2.2 Billing Defined

2.2.1 Billing Numerical Identifiers

There are many numbers associated and required for billing. It is imperative to not only understand them but to also understand how to obtain, find, change and explain them to your providers and staff. The following numbers and codes, along with the provider type, are required to set up the EMR. It is important to familiarize yourself with their descriptions to help determine where these codes need to be entered into your EMR and how the carrier uses them for claims. The specific codes that will be used on the claim include the POS, TOS, CPT and ICD-9(10). Also, depending on the type of service being provided (i.e., labor medications), you will need additional codes (such as CLIA or HCPCS codes).

NPI Numbers



You cannot bill for services provided before you obtain an NPI

As a clinic or provider wishing to bill insurance, the first thing you need to do is apply for a National Provider Identifier (NPI) number if you do not already have one.

NPI is a 10-digit number assigned to each provider or clinic in the US based on the type of care they provide. This numerical system was implemented in 1996 as part of the Health Insurance Portability and Accountability Act, or HIPAA, and replaces the previous Unique Physician Identification Number (UPIN). NPI was created to streamline the process of healthcare claim transactions, which include overall patient records, prescriptions and to help with coordination of patient benefits between multiple carriers. HIPAA requires that contracted entities use NPIs in standard transactions or daily claims.

There are two types of NPI numbers: individual and organization. They are obtained from a federal government organization called the National Plan and Provider Enumeration System (NPPES). Each provider must have an individual NPI number in order to bill. Some payers, such as Nevada Medicaid/HP requires that claims are billed using the clinic NPI because, as a Provider Type 17, Special Clinics – Public Health, they are not able to link our providers to the clinic. The provider's identifying number is generally required on claims, but in some cases the contracting carrier may prefer you to bill only with the clinic NPI (an example is Nevada Medicaid).

For More Information on NPI Numbers and to apply:
National Plan and Provider Enumeration System (NPPES)

<https://nppes.cms.hhs.gov>

1-800-465-3203

2.2.2 Codes

A. Taxonomy Codes

Taxonomy codes are an administrative code set to identify how providers/clinics are licensed and their area of specialty. These codes are an alphanumeric code of ten characters, and a provider or clinic can have more than one taxonomy, such as Public Health, Family Planning, TB Clinic, etc. Taxonomy Codes have 3 distinct levels that are specific to each provider specialty, but as Public Health you will be a level 1. Taxonomy codes get registered with NPPES at the time of NPI application. For further detail see: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>.

B. Provider Types

These codes are provided by the carrier once the credentialing process completes. The contracting department verifies the certifications or licenses of the provider and assigns a number to the provider/clinic based on the specialty of the provider or clinic. This helps the carrier maintain records for internal use, as well as help the claims department to process medical claims and the policyholder's specific benefits.

C. Place of Service Codes

Place of service codes let the carrier claims department know where services were provided. This code is required on the HCFA claim form in box 24B for all line items or they will be denied for missing information. As Public Health, you will generally use one code for Public Health Clinic, but based on your services you may use others, For example, #03 is a school-based clinic and can be billed during school-located clinics for seasonal flu or school district–required vaccines. Another option is #60, a Mass Immunizer, is for Medicare or private carriers that allow Roster billing. The first couple of pages in any CPT (old or new) book is a list of codes available to use based on your clinic or provider specialty, so always check with each carrier's billing manual or provider training department for more specific requirements.

D. Type of Service Codes

Type of service codes let the carrier/claims department know what kind of services were provided for the patient. Medical is #1 and the only code that Public Health will use, but being familiar with the complete list is a good idea, as you may find an alternative code for your clinic. To review all codes please follow the link <http://medicalbillingguideline.org/type-of-service-codes-tos/>.

E. Evaluation and Management (E/M) Codes

Evaluation and management codes are used to convey the level of care and time spent with the patient and must have the documentation to support it. There are multiple layers of complexity in determining what code to use for a patient visit, so this guide will provide only an introduction and overview of them.

The three essential components to assess when determining the E/M code to use are:

- History – what is the extent of the history being taken?
- Exam – what is the extent of the exam?
- Medical Decision – what is the complexity of the medical decision-making?

There are other additional qualifiers, such as counseling and time spent with patient, but keep in mind these need to be properly documented in order to warrant billing.

The following is a glimpse of the required documentation to qualify for the level based only on the history component:

E/M Code	TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
99201/ 99211	Problem Focused	Required	Brief	N/A	N/A
99202/ 99212	Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
99203/ 99213	Detailed	Required	Extended	Extended	Pertinent
99204/ 99214	Comprehensive	Required	Extended	Complete	Complete



This concept is important for the providers to fully understand prior to sending out your first bill!

F. CPT® Codes and Billing

CPT is an acronym for Current Procedural Terminology, which associates each service performed into a code form. Simply put, these codes tell the carrier what was done for the patient so the claim can be processed using the policyholder's benefits to help identify payable codes. Below is an example of vaccine codes used most commonly used in Public Health, although there are many more that are billable by public health departments. Some helpful reports can also be created using specific code information to help determine clinic productivity, service goals, and so on. A few of the vaccine CPT codes are listed here. (*See the Resources Section for a more extensive list of commonly used CPT Codes for Public Health*)

CPT Code	Description
90658	Influenza virus vaccine, 3 yrs.>
90715	Tdap vaccine 7yrs>
90649	Human Papilloma virus (HPV)

The AMA offers the Current Procedural Terminology, or CPT, book each year or you can find a download for purchase online. Often the vaccine manufacturer's representatives have resources that can also help you.

Be careful!

Some codes may have age or gender limitations, so watch for these to ensure a clean claim.

Keep in mind that you can also bill a low-level E/M code if you are seeing an IZ patient for something unique and separate from the immunization with a proper diagnostic code if the time spent meets the criteria.

1. HCPCS Codes

HCPCS is an acronym for Healthcare Common Procedure Coding System and is often pronounced by its acronym "hick pick" codes. Established in 1978, HCPCS codes were designed to include services that were not included in the CPT book. It began in an effort to provide a standardized coding system to describe specific items and services provided as part of the medical decision making and direction of care.

1. When HCPCS began billing these codes were not required and not reimbursed by any carrier; however, with the implementation of HIPAA, these codes now have become required to further describe transactions with healthcare information for Medicare, Medicaid and some private carriers, as well.
2. HCPCS are generally used to detail any Durable Medical Equipment given in office, including drugs and medical supplies.

2. ICD-9 Codes

ICD-9 is an acronym for International Classification of Diseases, 9th Edition, and these codes are used worldwide. For each CPT code on a claim, there will be a required diagnostic code. In the way the CPT tells the carrier WHAT service was performed, the ICD-9 tells WHY the service was provided. If multiple procedures are necessary, make sure the proper diagnosis code is tied to the correct CPT code.

ICD-9 numbers do not significantly change from year to year, although they do remove, omit and add new codes as needed.

3. ICD-10 Codes

The adoption of ICD -10 has been approved by the AMA but will not be effective until October 2015. If you are unfamiliar with what ICD-10 looks like, there are many online resources which explain their implementation. Preparation for the change includes the need to work with your clearinghouse or carriers and your EMR vendor to ensure the proper set-up is complete. Then you will want to send test files to ensure claims are processing correctly. A good resource until the ICD-10 is implemented is a review of the AMA ICD-10 CM mappings. Also, in the Resources section of this manual is a list of commonly used Public Health ICD-9 codes with a mapping to their ICD-10 equivalent. An example of the differences between ICD-9 and ICD-10 are shown in the following table.

Table 1 – Comparisons of the Diagnosis Code Sets

ICD-9	ICD-10
3-5 characters in length	3-7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First digit may be alpha (E or V) or numeric; digits 2-5 are numeric	Digit 1 is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality (i.e., codes identifying right vs. left)

Source: American Medical Association September 25, 2012 update



To get regular code and other updates, log into the CMS website and choose to receive email updates for all areas of interest.
cmslists@subscriptions.cms.hhs.gov

G. Modifiers

Modifiers are either alpha or numeric codes that give additional specificity to CPT codes by further identifying HOW services were provided. Modifiers are important to the billing process because they can make the difference in reimbursement. A modifier on certain CPT codes will avoid a bundled payment by letting the carrier know that multiple services were provided.

As Public Health, we will only ever use three modifiers, 25, 59 and QW. If you forget to add the proper modifier, charges may be denied for missing information or your claim could be underpaid due to bundling services.

Bundled payments are when the carrier makes the decision that certain codes are inclusive of other codes and only pays on one line item, while the provider is expected to adjust the difference. A good example to use is a Depo-Provera injection.

As a reminder, there are many different modifiers available, but the most commonly used codes for Public Health are listed below along with sample case scenarios.

- **Modifier 25** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. This modifier will only be used on an E/M code to let the carrier know that you have performed more than the office visit discussion. Watch for changes with BCBS, as they seem to change the definition of this modifier annually.
Example: 99212-25
- **Modifier 59** Distinct Procedural Service. For example, this modifier belongs next to a therapeutic injection code
Example: 93782-59
- **Modifier QW** CLIA Waived procedure, which means a Public Health clinic can bill and be reimbursed for certain lab-related tests done in-house. This modifier is not required on all lab codes or 80000 codes, so you'll need to familiarize the clinic with the tests you provide.
Example: 81003-QW

- **Modifier EP** Used for indicating routine Healthy Kids/Early Periodic Screening and Development (EPSDT) visit for Medicaid.
Example: 99382 EP
- **Modifier TS** Used for Medicaid EPSDT screening that needs a follow-up or referral (make sure the ICD-9 code reflects the abnormal finding). This is the same situation as above, the modifier is different.

H. CLIA Numbers

CLIA is an acronym for Clinical Laboratory Improvement Amendments, which began in 1988 and was initiated to create requirements based on the complexity of the test and not the type of laboratory where the testing is performed. It also defined that the tests were to be derived from the human body for the purpose of providing test results that would assist in decision of care for the patient. To apply for a CLIA certificate, follow the link <http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads>

What is a Waived Test?

CLIA tests are defined as waived tests, which are categorized as “simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.” The FDA reviews and determines the criteria for tests being simple with a low risk of errors and approves manufacturer’s applications for test system waiver. For your clinic, this means that if you provide lab tests and you would like to be reimbursed for them, you will need to apply for a CLIA certificate right away.

2.2.3 Claims Submission

A CMS-1500 claim form is the uniform professional claims form produced by the Centers of Medicare and Medicaid. A sample of the 1500 form is shown at the end of this section, followed by a detailed description of step-by-step instructions on how to complete the form.

Completing the CMS-1500 form is required to submit any claim unless you are roster billing (more on that later). A “clean” claim contains no data entry errors or mistakes, which helps to avoid a denial or potential delay for reimbursement.

There are basically two ways to submit a claim, on paper or electronically. Most payers are moving toward all electronic claim submission, but there are a few who allow paper claim submission.

Navigating health insurers’ systems and managing denials is often very time-consuming and difficult for billing staff to do. An organization can expend significant resources on billing, from claim

creation to payment. It is for this reason that most organizations have moved to submitting claims electronically. Also, due to the decrease in staff needed to process and pay claims, payers actually save money by choosing to receive claims electronically.

You need to ask the provider relations specialist from each insurer what their requirements are for claim submission. If you are planning on sending claims electronically, your Electronic Medical Record will need to be prepared ahead of time. Also, if you are billing more than a few insurances, you may want to use a billing clearinghouse to process your claims. You will still have to 'scrub' the claims for accuracy (more on that later), but the clearinghouse will also double-check them and send them out to the providers you choose.

By generating, submitting and processing claims electronically, you reduce the amount of manual data entry needed and thus reduce the potential for errors. The result is an expedited and generally cleaner claim because the insurers' system electronically adjudicates the claims with pre-loaded denial filters. This can be good (by expediting payment) or bad (by potentially incorrectly denying claims). It is for this reason that at the beginning of the contract process you start the conversation with the insurer on what is required for submittal of a clean claim.

A. Clearing Houses

A clearinghouse is a third party vendor who sends your medical claims to several payers at one time and is often referred to as providing Electronic Data Interchange or EDI service. Clearinghouses offer other useful services to help make the billing process as efficient as possible by checking your claims for accuracy, creating and scheduling patient statements to mail out, and productivity reporting, plus they can download all payments meant for you a week sooner than mailed payments. This means you can post payments well before the carrier EOB arrives.

Most clearinghouses are compatible with most EMR software and will work with you and your system to make sure all transfers are correct. The actual role of the clearinghouse is to take your data and input into an electronic claim format for the carrier's system.

You can choose to not use a clearinghouse, but that means more work for your staff. Some private carriers and Medicaid/Medicare offer billing options that transfer or deposit right into their system, but you need to manually enter all of the claim data, which can be very frustrating and unproductive.

Clearinghouses will charge for their service, but just like searching for software, you will need to interview each company to ask the following questions:

1. How do you charge for service? By claim, by line items on claims, or a flat rate based on current business numbers?
2. What kind of reporting does your system provide and, if needed, can we create our own reports? At what cost?
3. A clearinghouse will provide all known Payer ID numbers, which is like an address for a specific insurance company, but note that some smaller local plans may not have the capability to accept electronic claims and you will need to print a paper HCFA form to mail for processing.



Key Questions to Consider When Choosing a Clearinghouse

What is the cost?	What are the advantages vs. disadvantages	Could our practice do well without one?
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More Things to Consider

- Who is on their list of Health Plans they contract with? (you can usually find this on the website)
- Are the insurance companies you are contracted with on the payer list?
- Does the clearinghouse accept the claim format your billing system generates?
- What is their customer service rating satisfaction?
- Are there any early termination fees or is there a long-term contract?
- Can we check the status of submitted claims online or by phone?
- Do you offer secondary insurance claim submission and denied claim submission?
- Do you offer Quality Assurance Reports (i.e., of claim processing, errors/resubmission rates)?

B. Pros and Cons for Having a Billing Clearing House:

PROS	CONS
<ul style="list-style-type: none"> • Reduces claim errors, allowing the billing specialist to see and fix any errors • Less rejected claims return • Reduces paper claims • Allows Electronic Remittance Advice download • No need to prepare claims manually • Once claims are submitted, reimbursement times are much faster • Increases cash flow and billing specialist efficiency 	<ul style="list-style-type: none"> • Can be cost-prohibitive, with some clearinghouses charging up to \$100 per provider per month • Time needed for initial set-up can be arduous • If clearinghouse software has problems, it will slow down claims process and therefore remittance



Once your EMR is set up, you will need to test your electronic claims option to make sure your clearinghouse is communicating with your system to transfer claims to the carrier.

Now that you know what you need to set up your system and how you are going to get claims to the carrier, let's examine the CMS-1500 form and what goes where.

A useful resource is the Nevada Medicaid/HP Billing Instruction guide to help you determine what information needs to be on the HCFA 1500 for billing purposes. Although this information is directly related to Medicaid, the same information needs to be on all claims for all carriers.

All of the provider/clinic information will need to be set up in your EMR, such as your Taxonomy code, Provider Type, Place of Service codes and Type of Service codes, which will be detailed in another module.

On the following page is a sample CMS 1500 form, followed by explanation of what is generally required to complete for Nevada Medicaid.

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

Effective April 1, 2010
Change to Fields 17 and 17a

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> OPAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (2010 or 01) <input type="checkbox"/> FICA <input type="checkbox"/> (2010 or 01) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) <input type="checkbox"/>										1a	
2			3			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (no, Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (no, Street)					
CITY		STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code)	9. EMPLOYED <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (Include Area Code)			
9			10			11					
9a						11a					
9b						11b					
9c						11c					
9d						10. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____					SIGNED _____						
14					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE: MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19					20			21			
21					22			23			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain unusual CDM responses)	D. DIAGNOSIS (ICD-9-CM)	E. CHARGES	F. DATE OF SERVICE	G. FREQ PER PERIOD	H. ICD-9-CM	I. READ/REFS PROVIDER ID #		
A		B	D	E	F	G	H	I	J		
2								NPI			
3								NPI			
4								NPI			
5								NPI			
6								NPI			
25			26		27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28	29	30		
31			32		33		33a	33b			

Fields 24:

2
3
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CARRIE
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Required (R)	Optional (O)	Not required (NR)	Suggested (S)
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	Field Number	Instructions
NR	1	Check mark if Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, GHP, FECA, Black Lung, other. It can usually be set up in EMR.
R	1a	Insured's ID Number (11 digit Recipient ID). Medicaid only
	2	Patient's name (recipients full last, first name and middle initial).
	3	Patient's Date of Birth, gender. DOB in MMDDCCYY.
NR	4	Insured's name.
	5	Patient's address, City, State, Zip Code, Telephone.
	6	Patient's relationship to insured.
	7	Insured's Address, City, State, Zip Code, Telephone.
	8	Patient status = Marital Status
	9	Other insured's name.
	O	9a
NR	9b	Other insured's date of birth, gender.
	9c	Employer's name or school name.
O	9d	Insurance plan name or program name.*
	10 a-c	Check mark if patient's condition is related to work- related accident, or other accident.
NR	10d	Reserved for local use.
O	11	Insured's policy group.*
NR	11a	Insured's date of birth, gender.
NR	11b	Employer's name or school name
O	11c	Insurance plan name or program name.*
NR	11d	Is there another health benefit plan?
	12	Patient's or authorized person's signature.
	13	Insured's or authorized person's signature.

	Field Number	Instructions
O	14	Date of current illness, injury if work related, and pregnancy if billing global Obstetrician care. Enter date in MMDDYY format.
NR	15	If patient has had same or similar illness.
	16	Dates patient unable to work in current occupation.
	17	Name of referring provider or other source.
	17a	Not labeled.
	17b	NPI.
	18	Hospitalization dates related to current services.
O	19	Reserved for local use. Where you add CLIA# for labs or general notes per carrier.
NR	20	Outside lab Charges if any.
O	21	Diagnosis or nature of illness or injury.*
	22	Medicaid resubmission.*
	23	Prior authorization number. Enter prior authorization number without dashes, hyphens, spaces, etc.
R	24	Date (s) of Service. Enter the begin and end dates of service in MMDDYY format.
NR	24c	EMG. Emergency services Identifier.
R	24d	Procedures, services or supplies CPT/HCPCS modifier.*
O	24e	Diagnosis pointer.*
R	24f	Charges. Enter your usual and customary charge for the CPT/HCPCS/NDC on this claim.
	24g	Days or units. Enter number of days or the number of units being billed.
O	24h	EPSDT/ family plan. Enter Y for providers billing Family Planning and N if not applicable.
R	24i	ID qualifier. Will always be ZZ for Medicaid and not required by all carriers*
	24j	Rendering provider ID#. Taxonomy codes are not required by Nevada Medicaid and are not denied if on claim. NPI# on 24J should match NPI# on 33b
	25	Federal Tax ID number. Public Health bill under Clinic NPI tax ID not Social Security Number. Private offices can bill under SSN if no NPI assigned.
S	26	Patient's account number. Enter up to 17 alpha-numeric for your internal patient account number.
NR	27	Accept assignment?
R	28	Total Charge. Add all amounts in column 24F and enter the total in this field.

	Field Number	Instructions
O	29	Amount paid. Enter amounts paid by all other carriers including Medicare.
R	30	Balance Due. Enter the amount in field 28.
	31	Signature of physician or supplier. The billing provider or authorized representative must sign and date this field. Original rubber stamp and electronic signatures are accepted.
O	32	Service Facility location information and address. Enter the name and full address of the location where service was rendered. Do not use spaces, dashes, hyphens, etc.
NR	32a	NPI#
	32b	Other ID#. Leave blank.
R	33	Billing provider info and Ph.#. Enter the billing provider's phone number and full address. Do not use spaces, dashes, hyphens, etc.
	33a	NPI#. Enter the billing provider's NPI. Enter NPI for Public Health Clinic for Medicaid.
O	33b	Other ID#. Per Nevada Medicaid, NPI# in box 33b MUST match NPI# in box 24j.
O	33b	Taxonomy Codes are not required and are not denied if on claim.

* NOTE: **Fields 9a and 9d:** If recipient has Medicare coverage, Medicare information must be entered.

Fields 11 and 11c: If Medicare is secondary, enter primary carrier information.

Field 21: Provider Types 30, 38, 39, 48, 57, 58, 83, and 84 are not required and should leave this field blank. **All other provider Types are required and should enter up to four ICD-9 codes on lines numbered 1-4.**

Field 22: Complete this field to adjust or void a previously paid claim. Otherwise leave this field blank. **Resubmitting a denied claim is not considered an adjustment. Only for Medicaid and only if related to underpayment.**

Field 24d: Procedures, services, or supplies CPT/HCPCS modifier:

CPT/HCPCS Code: Enter *one* CPT or *one* HCPCS code and up to four modifiers on the **bottom, white half** of the claim line. **Effective January 1, 2008**, Medicaid does not require HCPCS codes when billing for physician administered drugs; bill with NDC instead, unless billing IUD.

If the recipient has TPL (including Medicare), use the same

HCPCS code and modifier(s) for all payers.

Physician Administered Drugs: Since January 1, 2008, an NDC quantity is required when billing for physician administered drugs.

In the **top, shaded half** of the claim line, enter the NDC quantity, i.e., the number of NDC units administered. For example, 3 mos. of Desogen = NDC#, remove HCPCS and add 3.0 above HCPCS area;, all others, for example, Depo-Provera = 1.0 units.

Do not include the NDC standard unit of measure on your claim i.e., *milliliters, grams or each*.

Several payers have continued to require HCPCS codes and units on claims post January 1, 2008. On TPL and Medicare crossover claims, enter the drug's HCPCS code and units in the **bottom, white half** of the claim line and NDC and NDC quantity on the **top, shaded half** of the same claim line.

Field 24e: Diagnosis pointer: In the **bottom, white half** of the claim line, enter the line number(s) of the diagnosis code in Field 21 that relates to the CPT/HCPCS code on this claim line. On a standard HCFA you can display up to 4 Diagnosis codes, although your EMR may allow more.

Field 24i: Using NPI in Field 24J: Enter ZZ in the **top shaded half** of the claim line.



It is important to note that this is merely a guide for completing a CMS 1500 form and you must follow current guidelines for each payer's requirements for completion.

During the process of setting up your EMR and obtaining your billing numerical identifiers, you have reached out to the payers and sent a letter of intent to contract (*see sample in Contracting section*). Next you need to prepare for the credentialing requirements that are necessary to complete. It is important to know that the payers will not want these forms completed and returned until they ask for them. The following will provide an overview of what is involved in credentialing. Many of these processes are able to be done simultaneously.

2.2.4 Credentialing

Credentialing is an important step in medical billing because it is a process for the insurer to verify providers interested in contracting with them. A public health agency or its healthcare providers must be credentialed as participating providers (PAR)—this includes MDs, DOs, ARNPs, PAs—in order to contract. Due to the potentially large amount of documentation, this process can be quite labor intensive.

Credentialing, like contracting, helps to protect the insurance company, the public, and providers from fraud by closely examining the identity, education and professional credentials of providers. It

will also disclose any malpractice suits, claims history, license restrictions or sanctions which may have occurred in the past.

When the credentialing process is complete and approved, a contract is offered to the agency or healthcare providers, which can take anywhere from 60-180 days before the final executed contract is received.

A. Steps to Credential

The carrier will send a packet to the provider that needs to be thoroughly completed. This packet will let you know exactly what documentation they need to accompany it. The credentialing packet must be completed for all providers who will be billing insurance. In Nevada you must use the NDOI-901 form, an example of which can be found at the following website:

http://www.multiplan.com/pdf/providers/howtowork/credentialingforms/NV%20Uniform%20Credentialing%20Form%20901_v.%20Mar%202007.pdf

Once the packet is complete and mailed back, the insurance company will contact you for the next steps (some may want to do a site visit prior to sending any contract information).

B. Checklist for Credentialing

- ✓ Tax ID*
- ✓ Taxonomy Codes
- ✓ National Provider Number (NPI)
- ✓ Universal Credentialing Application
- ✓ Credentialing Documents

*A Tax ID number (TIN), sometimes known as an Employer Identification Number (EIN), is required in order to be credentialed. Each agency should have a Tax ID Number. (Often, the public health agency will operate under the county / or city's Tax ID and, therefore, the contract may have to be set up with a DBA (doing business as) to differentiate the public health clinic from the remainder of county services that may be billed for.

C. Credentialing Documents

The following is a list of some of the most commonly requested documents, but you will need to follow the request of the individual payer:

- 1) Personal Information
- 2) Provider/Clinic NPI
- 3) Provider/Clinic Tax ID or EIN#
- 4) License Numbers and Copies of State license
- 5) DEA Numbers
- 6) Educational History
- 7) Board Certifications
- 8) Private Practice Details and Work History
- 9) Association Memberships
- 10) Proof of Liability Insurance
- 11) Peer References
- 12) Association Memberships
- 13) Completion of the Practitioner Questionnaire regarding malpractice or other disciplinary actions
- 14) Have provider or clinic director sign the signature lines. This depends on who you are contracting with and how they are contracting public health. Some carriers will contract

You are able to use a copy of the original as long as the information doesn't change, but you will need a newly dated and signed application if it's over 6 months old. You will need to add updated licenses, insurance and board certifications, as necessary. Re-credentialing is required every 3 years.

D. Shared Experiences

- Many clinics do not want to have all their providers get NPI numbers. In some cases you can bill under the clinic's NPI, but it is best to check with the individual insurance plan.
- Many private insurers do their own credentialing.
- It usually takes approximately 2-3 hours the first time you complete the required credentialing paperwork.
- It helps to send a list of needed documents to your providers so they can pull all of them at one time and contact you when they are ready.
- One of the City's public health clinics contracted with the City's Tax ID but later found out that Fire/EMS also billed under the City's TIN. Subsequently payments were sent to the incorrect address.

2.2.5 Contracting

Contracting is the process of becoming an “in-network” provider with a specific insurance carrier, which in turn allows your patients to benefit by being responsible for less of the overall cost of the services provided. In addition to the convenience for the patient, the provider can benefit as detailed below:

- ✓ Establishes a legal relationship offering both parties protection
- ✓ Defines the provider’s responsibilities to plan members and ensures a standard of care for services
- ✓ Establishes the claim filing process (are both electronic and paper claims accepted?)
- ✓ Details the procedure for the issuance of payments
- ✓ Defines the fee schedule; what is the set amount an insurer will pay for each CPT code billed by the Agency
- ✓ Details requirements regarding co-payments, deductibles and other factors affecting the Agency’s billing program
- ✓ Adds your provider/clinic information to the regularly updated provider directory that is given to all members of the plan, which can increase overall clinic production (*for more about this, see Lessons Learned*)

A. What Are the Steps Involved?

1. Determine with whom you wish to contract, (i.e., who are the top insurers in the area you serve?) This information can be obtained by conducting a survey of the clients coming to your clinic. (*see Resources for an example of a survey*)
2. Contact the contracting specialist for each insurance company you wish to contract with to ask what their specific requirements are. The contact is usually listed on the insurance company’s website.
3. Most insurances will require a letter of intent (see sample on next page as well as the template in the appendix), which includes:
 - a. Address of the clinic/provider(s) you wish to contract
 - b. Roster of providers (by location if indicated) and their NPI numbers*
 - c. A simple list of services provided; for example, Immunizations, Family Planning and Well Child checks
 - d. A copy of your W-9

The “Letter of Intent” to contract should have your provider names, dates of birth, and your clinic NPI numbers. In this letter, you will describe the types of services you wish to bill for. You will then send the letter to the point of contact (usually the provider relations or contracting specialist).

Health departments should be aware they may experience some resistance from insurance companies when asking to contract because many insurers may lack familiarity with the public healthcare model. The biggest difference in the public healthcare model compared to the private sector is having a physician on-site during hours of operation. Since many LHDs have nurses or nurse practitioners providing care, the insurers may be reluctant to contract. It may be beneficial to ask if they have contracts tailored to public health, or another option would be to contract under the clinic as the provider if they are agreeable to that. It is important not to give up simply because they may not have a place to put a health department in a provider directory.

Sample Letter of Intent

[Your Name]
[Street Address]
[City, State Zip]
[Email Address- Optional]

[Today's Date]

[ATTN: Name of Recipient, if you have any]
[Title: Title of the recipient, if you have any]
[Company: Network Contracting Department]
[Address]
[City, State Zip]

[Dear (Name of the Recipient, if you have any), if not use To Whom It May Concern:]

Please accept this letter as our interest in contracting with (carrier name) and your network partners. We are a Public Community Health Clinic providing the (area you serve) with immunizations, well-baby checks and Women's and Men's care.

The practice addresses are as follows:

[Name of Clinic: for example: ABC Clinic]
[Address for example: 123 Main St.]
[City, State Zip; for example: Las Vegas, NV 89000]
[Phone Number; for example: 702-123-4567]

Tax ID# 00-1234567

Staff Providers:

John Doe, MD, NPI: 987654321 (Collaborating Only)
Donald, Duck, APN NPI: 123456789
Minnie Mouse, APN NPI: 456321782

I look forward to hearing from you soon, so we can begin the contracting process.

Thank You,

Sincerely,

[Sign here for letters sent by mail or fax]
[Your typed Name]
[Department]
[Direct Phone Number]

B. State Your Case

<p>HDs see many of your clients because they can't get in to see their physician and need services.</p>	<p>HDs provide services that are needed right away. For instance, for treatment of a sexually transmitted disease.</p>	<p>HDs are often a primary resource for immunizations at back-to-school time. (Families need to get in right away; and many primary care providers either choose not to carry vaccines</p>	<p>HDs benefit underserved populations, improving access to care for plan members</p>
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Once the letter of intent is accepted by the carrier, the insurance company will provide a list of codes and their proposed reimbursements for those codes. If these rates are acceptable, the Agency will send a signed agreement back and then the credentialing process will begin. Your contracting specialist will provide you with the next step to accomplish this.

Once the Letter of Intent has been processed, the general documents that you should begin to gather are: copies of licenses, liability insurance certificates, DEA and state pharmacy licenses and, usually, a provider's CV or résumé. The credentialing process can take anywhere from 90-180 days.



Key Points to Remember

<p>Generally, there is little negotiation involved in the contracting process. Agencies will be issued a contract based on their usual and customary payments and if they wish to negotiate the reimbursements they will do so with the contracting specialist.</p>	<p>Track all steps throughout the credentialing and contracting process, including dates applications were submitted. Applications can often be misplaced by insurance companies. A Tracking Log Sheet to monitor and follow up on credentialing and contracting submissions is located in the resource section.</p>	<p>After submitting a contract application, there is often a delay while waiting for receipt of a contract and effective date. The Agency will only be compensated for patient services after the effective date.</p>
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C. In-Network vs. Out-of-Network Provider

An in-network provider is defined as one that has a contract with the insurer to provide services to their clients. In rare instances, it is possible to receive reimbursement from some insurance companies when the provider or Agency is an "out-of-network" provider. When out-of-network providers receive compensation for services it is significantly less, if payment is received at all. In some cases, insurance companies may send the out-of-network payment directly to the patient. This requires the Agency to collect payment from the patient, which can be a difficult task. When a

patient presents an insurance card for a non-participating insurance company, call the telephone number on the back of the card to determine if reimbursement can be received.

D. Looking at the Figures

Generally, contracting can establish a higher rate of reimbursement for in-network providers. For immunizations services, a contract will determine how the final amount paid is calculated. The write-off amount is the difference between the fee charged and the contracted allowed amount. A contract will also determine whether or not the difference between the allowed amount and the paid amount can be billed to the client.

For example, if your fee is \$25 and the insurance allows \$20, the write off amount is \$5. If the insurance only pays 80 percent of the allowable amount (\$16), then you may be able to charge the patient the remaining 20 percent (\$4). However, you must bill established fees across the board for all payers regardless if it is the patient, Medicaid or BCBS.

E. Negotiations

Generally, due to the limited and focused services public health clinics provide, there will be no need for contract negotiations; however, if you have reimbursement rates that are below the clinic costs, you can speak to your contracting specialist to explain your cost and see if they will increase the reimbursement to match your cost.



Key Lessons Learned

- Your reimbursement will be better if you are an in-network provider
- Often you can speak to your contracting specialist if their reimbursement is lower than your cost; show them your invoice and they may pay

2.2.6 What Happens Now?

Once you are contracted and begin seeing clients, it is helpful to understand what the process is from start to finish. The following chart provides a description of what happens once you have submitted the claim to the insurance company.

Typical Health Insurance Claims Processing Workflow	
Step One:	Receive claim in their system (either through your EMR, a clearinghouse or from a billing agency on your behalf)
Step Two	Patient's eligibility and coverage is determined (do they have current benefits and do those benefits cover the services billed for?)
Step Three	Apply pricing claim edits (what they are contracted to pay for the services)
Step Four	Apply health insurer claim edits (are there any applicable co-pays, deductibles, etc. which need to be applied)
Step Five	Complete adjudication (determining final payment)
Step Six	Generate the Explanation of Benefits and Remittance Advice (EOB, RA)
Step Seven	Send the payment (either through Electronic Funds Transfer or manual check mailed)

A. Claims Denials

What do you do if the insurance company did not pay your claim? It is a fact of the medical billing industry that insurance carriers *will* and *do* deny perfectly clean claims in error, but do not write off the balance just yet! Denials can easily be described as the most frustrating aspect of billing

because you need to follow up with the carrier to get this claim paid. Denials occur for many reasons, such as, the patient was not eligible for benefits at the time of service, specific services are not a covered benefit of the policyholders plan, or they cannot identify the patient.

The first step is to review the Explanation of Benefits to help determine why the claim was denied and what needs to occur to get it reimbursed as quickly as possible. If the reason is that the patient was not eligible for benefits at the time of service, you will change the financial responsibility to the patient. In public health we understand that collecting this money is not always possible due to financial hardship.

Other denials may be very simple to correct, such as an incorrect ID#, which can simply be re-billed without any communication with the carrier. There are other reasons which may require you to submit progress notes, copies of cards, or other simple requests directed at either the provider or patient. The other important denial is due to lack of preauthorization and, in this case, there is really nothing that can get this particular claim paid unless the service was provided during an emergency situation.

Additionally, a whole claim can be denied or a specific line item can be denied. If there is only a line item missing, you will need to remove the paid or processed charges from the claim form. You should be able to uncheck line items in your EMR. There will be times that you send a claim that you know is correct yet it has been denied. If there is no simple fix, you may need to call the carrier to get specific answers and they may direct you to send an appeal form with supporting documentation. This is considered an appeal, which allows you to state the reasons the claim should be paid. Most carriers have their own form that they would like you to use for uniformity, and once you send this back allow at least 30 days for processing.

B. Explanation of Benefits and Remittance Advice

Once the insurance company has paid your claim, you will receive an Explanation of Benefits, or EOB, along with a payment or denial. This explanation of benefits is often muddled with codes that may or may not have definitions. This part of the billing process can become a nightmare if you are not prepared to persevere and dedicate the time needed to learn and understand the insurance company's lingo. There are thousands of denial and claim explanation codes, and listed below are only some of the top codes you might encounter.

Claim adjustment reason codes (CARCs) reflect an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

This is a list of the top 10 CARCs:

1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender

Another type of code commonly used is a Remittance Advice Remark Code (RARC), which is defined as a code used to provide additional explanation for an adjustment already described by a Claim CARC or to convey information about remittance processing. Each RARC identifies a specific message, as shown in the Remittance Advice Remark Code List. There are two types of RARCs, supplemental and informational. The majority of the RARCs are supplemental; these are generally referred to as RARCs without further distinction. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC.

The second type of RARC is informational; these RARCs are all prefaced with **Alert:** and are often referred to as Alerts. Alerts are used to convey information about remittance processing and are never related to a specific adjustment or CARC. These codes are generally describing something that was missing for the claim to be paid, or that additional information was needed, asked for and not received.



It is a good idea to get the codes your insurance companies use from them (they have to share them with you). If the description is not clear, make sure to ask and then keep the definitions in a folder so you can easily access them.

C. Payments – Receiving and Posting

Once you receive the payment, you will need to examine the document carefully. This document should mirror your claim from a data standpoint, but you will also see an allowed amount column, amount of patient responsibility based on plan deductible, patient co-insurance or co-pay, and how much they paid, plus any contract adjustment.

You will need to enter this information by using the claim number or account number that will be on the EOB. Enter all necessary information into your EMR and watch for patient responsibility, which means you will need to identify what charges are the patient's responsibility, and send the patient or guarantor a statement requesting payment. Most insurers have the ability to automatically deposit claim payments into your bank account via Electronic Fund Transfers (EFT), or you can still receive live checks to deposit.

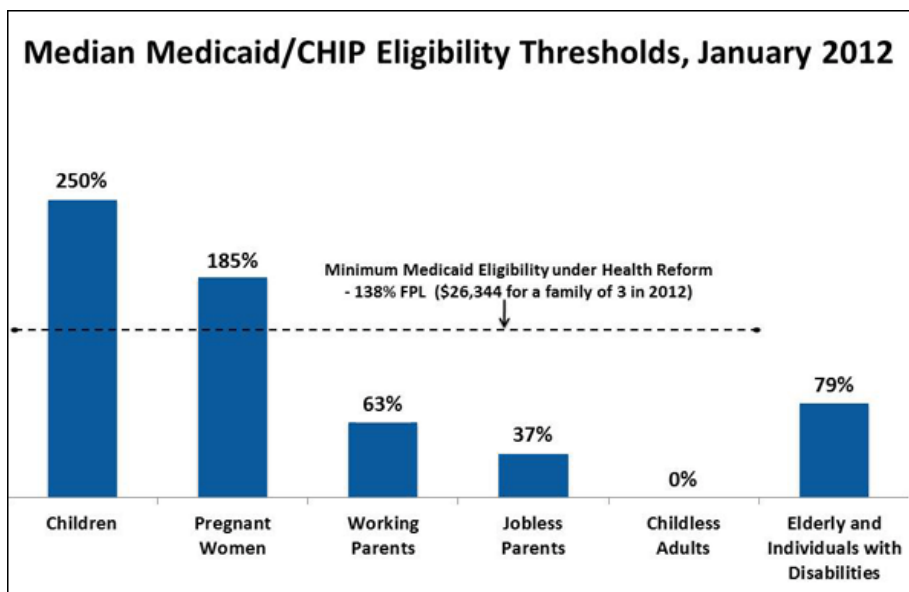
If you are set up for EFT payments, you will receive an electronic version of an EOB, which is referred to as a Remittance Advice (RA) or 835. These forms explain the status of the claim. You will follow the same instructions for entering payment, adjustments and responsibility as you did for a paper check. Always be sure to scan your EOBs into a database, as you may need to print them if sending to a secondary carrier for payment.

2.3 Medicaid

2.3.1 Overview

Medicaid is a Federal program which originated in 1965 with the goal of providing healthcare for individuals and families who meet eligibility requirements. States are required to provide certain medical benefits and have the option to provide more. Federal guidelines define the mandatory groups and services to be covered. Because the states have such flexibility in what they choose to provide, Medicaid coverage varies greatly from state to state. The groups covered by Medicaid include the severely disabled, children, pregnant women, and parents and seniors who meet the financial eligibility criteria.

Currently a family whose household income is at or below 138% of the Federal Poverty Level (FPL) qualifies for Medicaid assistance. The Patient Protection and Affordable Care Act (Affordable Care Act) expands Medicaid in 2014 to cover all non-elderly Americans with incomes below 133 percent of the federal poverty level. These new guidelines went into effect as of January 1, 2014. Below is a chart which demonstrates how many individuals were not covered in 2012 under the current FPL eligibility threshold. Research indicates that the Medicaid expansion could reduce the uninsured rate among low-income adults up to 70 percent.¹



SOURCE: Based on the results of a [national survey](#) conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

2.3.2 Medicaid in Nevada

In Nevada, Medicaid was adopted in 1967, and since 1997 has been administered by the Division of Health Care Financing and Policy (DHCFP). In addition to administering Medicaid, DHCFP also administers the Children's Health Insurance Program (CHIP), which in Nevada is called Nevada Check Up (NCU). NCU provides healthcare benefits to uninsured children who do not qualify for assistance but whose family income is \leq 200% of the FPL. Medicaid reimburses contracted providers of care for services provided to eligible recipients. Eligibility is determined by the Division of Welfare and Supportive Services (DWSS).

Some of the benefits provided to Medicaid recipients at public health clinics are:

- Birth Control/ Family Planning
- E/M (Evaluation and Management) or Office Visits
- Healthy Kids/ EPSDT/ Wellness Exams/
- Prescription Drugs (given in office)
- Immunizations
- Healthcare, including diagnosis and treatment of Sexually Transmitted Diseases
- Healthcare, including screening, diagnosis and treatment for active Tuberculosis

2.3.3 Becoming a Medicaid Provider

To become a Medicaid provider, you must complete the Provider Enrollment Application Form FA-33 (*see Resources and Forms section*). This application can be found on <http://www.medicaid.nv.gov/providers/enroll.aspx>.

Be sure to follow the directions carefully and send all requested documents to avoid delays. The application is then processed and can take up to 2 to 6 months, so be prepared. It is recommended to call provider enrollment at least once a month to check the status of the contract. You will need to know what your provider type is (Public Health is 17) and any subspecialty type (i.e., family planning, TB or just Public Health).

A helpful guide for provider enrollment can be found at:

http://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf.

A. Provider Types

There are 60 different medical service ‘provider types’ within the Nevada Medicaid system. Some providers provide more than one type of service. You must submit one complete set of enrollment documents for each provider type you are enrolling. For example, if you supply Durable Medical Equipment (provider type 33), as well as pharmaceutical drugs (provider type 28), complete two sets of enrollment documents. The same NPI would be noted on each application. The difference between the two applications would be the provider type number and the attachments required per the enrollment checklist instructions.

B. Taxonomy Codes

As stated earlier, taxonomy codes are usually only required when billing federal programs such as Medicaid and Medicare. These codes define the provider type and any specialty associated with them. Taxonomy codes are not required when obtaining an NPI, but you will need them to bill Medicaid. You can go to this link to get a taxonomy code: <http://www.wpc-edi.com/codes/taxonomy>. A few examples of taxonomy codes used by LHDs in Nevada are listed below.

Nurse Practitioner	363L0000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
	363LW0102X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Women’s Health
	363LC1500X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Community Health

2.3.4 Medicaid Managed Care

The DHCFP contracts for the delivery of healthcare through managed care organizations for certain Medicaid and NCU populations. The objectives for the program are improved access to care and coordination of care, and management of the cost of services. Managed care is only available in the urban areas of Washoe County and Clark County. It is currently administered by two organizations, which include Health Plan of Nevada (HPN) and Amerigroup Community Care.

A. Health Plan of Nevada

Health Plan of Nevada (HPN) is a United Healthcare Company that manages Nevada Medicaid recipients' care, offering a wide range of benefit plans for the Nevada Community. Health Plan of Nevada serves Clark County under Smart Choice and Washoe County under Northern Choice.

For more information on Health Plan of Nevada visit:

http://www.hpnmedicaidnvcheckup.com/benefit_plans/SmartChoiceNorthernChoiceMemberHandbook.pdf

B. Amerigroup

Amerigroup serves Medicaid members in 13 states across the United States, offering a wide range of benefits. In Nevada, Amerigroup is offered in Clark and Washoe counties. In order to be eligible to receive medical benefits with Amerigroup through Nevada Medicaid, you must:

- ✓ Be a pregnant woman
- ✓ A family with children
- ✓ Be 21 years or younger

As with HPN, Amerigroup members must choose a primary care provider upon enrollment and their care must be facilitated through that provider. As a public health clinic, many services can be covered if the client does not have access to another provider, but coverage will be determined by the client's case manager.

To find out more information about Amerigroup in Nevada visit:

<http://www.myamerigroup.com/English/Medicaid/nv/Pages/Nevada.aspx>.

Important to note: both Medicaid HMO plans must be contracted with separately and have individual fee reimbursement schedules and requirements.



Key Questions to Consider

How many MCD HMO clients does my clinic see?

Do we need to contract with these Plans?

2.3.5 Immunizations and Medicaid

Nevada Medicaid adheres to the CDC schedule for vaccines based on age and need. Nevada Medicaid will not reimburse any vaccines that are covered under the Vaccines for Children or VFC program, but will pay the administration charge. Covered immunizations not included in the VFC program will be reimbursed per the Pharmacy Manual. Physicians and clinics bill for vaccines using their CPT Code and pharmacists bill for the vaccines by the National Drug Code. Nevada Medicaid reimburses on a per-admission basis and not on a per-component or per-antigen basis.

Some of the covered vaccines for adults on Medicaid include:

- Influenza
- Tetanus, diphtheria, pertussis (Td/Tdap)
- HPV (male and female)
- Measles, mumps, rubella (MMR)
- Pneumococcal
- Hepatitis A
- Meningococcal
- Hepatitis B
- Inactivated poliovirus
- Hib



2.3.6 Client Eligibility Verification

There are several ways to verify patient eligibility prior to providing services. The first option, the Nevada Medicaid Portal, is free and is available as long as you have internet access and a login/password for Medicaid.

A. Nevada Medicaid Portal

The Nevada Medicaid Portal is a web-based link. You will need to sign up as a provider to gain access and then create a user ID and password. You will need the client's Medicaid number, name and date of birth to check eligibility. This option gives you the choice of printing the paper verification for your records, but please see *Lessons Learned* regarding this option. The Medicaid portal link is:

<https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>



B. Magnetic Card Reader

Another alternative is to purchase and maintain a magnetic card reader, which can be obtained from Emdeon™ (*for more information visit www.emdeon.com*). There is a charge for this service, which is determined by the number of eligibility verifications you run each month. The process of eligibility verification is simple. You swipe the Medicaid card that has a magnetic strip on the back and then select their insurance carrier and enter the ID#. The system will print out a record of whether they are eligible for benefits at the time of service. The whole process takes under a minute. Keep in mind this does NOT have anything to do with prior authorization. It merely provides the staff with the client's current Medicaid status; it also will display if the client is enrolled in the Managed Care plan or regular Medicaid. This machine can also function as a Point of Sale (or credit card) machine.

2.3.7 Claims and Billing

A. Paper Claims

Nevada Medicaid requires different claim data based on the provider type Medicaid assigns you. To get an in depth view of what a completed claim should look like, please refer to the following link: <http://www.medicaid.nv.gov/providers/BillingInfo.aspx>.

The instructions on how to fill out a claim can be obtained at <http://www.medicaid.nv.gov/providers/training/training.aspx>.

B. Direct Data Entry

If you do not have an electronic medical record, your billing can be done by direct data entry to the Medicaid Claim site: <http://www.payerpath.com/>

C. Electronic Filing

If you have an electronic medical record and wish to submit your claims electronically, you will need to work with your software vendor or IT staff to make sure all required fields are set up to be populated. Nevada Medicaid also has the ability to send your payments electronically via electronic fund transfer. In any format, the importance of accurate CMS 1500 form completion cannot be emphasized enough. If it is not completed correctly it will be denied, thus delaying, if not eliminating, your reimbursement potential.

D. Training

Medicaid and their claims' processing organization (HPES) have regularly scheduled provider trainings where they show providers what is needed to process clean claims. They are also willing to do additional trainings or meetings if there are questions or problems.

E. Lessons Learned (Note: These lessons learned are for Medicaid non-HMO plans)

Checking a patient's eligibility via the Medicaid website can be time-consuming if your schedule is hectic, and it can also time you out if you need to refocus your attention.

- 1) Billing Medicaid may be slightly different based on the provider type and how the group NPI is billed. Normally you would enter the rendering provider NPI in box 24J of the HCFA form; however, because Medicaid cannot link providers to the clinic (system limitations), we are required to use the clinic NPI .
- 2) Whatever number that is in box 24J needs to be the same as box 33B or leave both blank.
- 3) Add the ZZ provider ID type on all claims (in box 24I in shaded portion) if you cannot set up automatically in your EMR.
- 4) Billing drugs given in the office vs. giving a prescription. When billing Medicaid for drugs they require the following information to process the claim:
 - a) Remove the NDC# for all IUD products and only bill the HCPCS code.
 - b) For all other medications, bill with the appropriate NDC# and white out the HCPCS code.
 - c) Add the quantity in box 24D in the red shaded portion and use whole numbers such as 1.0 for 1 unit, 2.0 units, and 3.0 represents 3 months of packaged birth control pills.
 - d) All paper claims must be signed.
 - e) An appeal is only useful if the claim was processed incorrectly and you have re-billed with no resolution. Complete the Appeal Form FA-90 and submit all required documentation and allow 30 days for a reply.
 - f) If a claim is underpaid according to your reimbursement list, you will need to resubmit the claim using the 4 digit adjustment reason codes that can be found on the Nevada Medicaid website.
 - g) Make sure there is no payment information in box 29 or the claim will be denied.

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2.4 Medicare

Medicare is a federally funded health insurance program for people over 65 years of age, people under 65 years with disabilities, and people of all ages with End-Stage Renal Disease. Medicare offers Part A, Part B and Part D. In some cases, people prefer to add part D, which is an optional plan that covers drugs that Medicare B might not cover.

- Part A – Emergency care and Hospital/Inpatient visits
- Part B – Medical testing, Outpatient doctor visits, etc.
- Part D – Prescription Plan
- Medicare Advantage Plan – HMO/PPO coverage

Medicare has recently offered Medicare Advantage Plans, which are similar to a Health Management Organization (HMO) or a Preferred Provider Organization Plan (PPO) to try and save costs, but vaccines do not require pre-authorization from the primary care physician. A good resource for providers that want to learn about Medicare is:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>.

2.4.1. How to Become a Medicare Provider

Medicare provider enrollment can be time-consuming. The enrollment process involves submitting the appropriate Medicare Provider/Supplier Enrollment forms, such as the CMS-855I, CMS-855B, CMS-855S, and CMS-855A. Or you can use the Provider Enrollment, Chain, and Ownership System (PECOS) to enter your enrollment application online. The PECOS system uses your NPI login information to connect to the Medicare Provider Enrollment system. All information for Internet-based PECOS can be found by logging on to the Medicare Provider and Supplier Enrollment webpage (www.cms.gov/MedicareProviderSupEnroll) and clicking on the *Internet-based PECOS* link located on navigation menu. When a paper provider enrollment form is submitted to a Medicare contractor, the enrollment department keys the paper application into PECOS for processing the application against all the enrollment requirements.

Medicare will typically take 60 days to process enrollment applications for individual providers. Applications for facilities, DME companies, Home Health agencies, Independent diagnostic testing facilities, and other organizations can take longer due to the stringent enrollment requirements, including site visits. The time frame for application completion varies widely based on the work queue of the contractor.

A copy of the Medicare enrollment application can be found at:

<http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp>.

The following forms may be required in addition to the Medicare Enrollment Application:

- Electronic Data Interchange (EDI) Enrollment Form.
- Centers for Medicare and Medicaid Services EDI Registration Form (agreements executed when you submit electronic claims or use EDI, either directly with Medicare or through a billing service or clearinghouse).

These forms must be completed prior to submitting EDI transactions to Medicare; plus Form CMS-460/Medicare Participating Physician or Supplier Agreement, which is the agreement you will submit if you wish to enroll as a Part B participating provider or supplier.



Key Tips to Follow to Aid in the MCR Enrollment Process

1. Consider using PECOS
2. Make sure you have the current version of the CMS-855 (enrollment form)
3. Submit the correct application for your provider type
4. Submit a complete application
5. Submit the EFT Authorization Agreement (CMS-588) if you want electronic funds transfers
6. Submit all supporting documents
7. Sign and date the application
8. Respond to requests for additional information quickly

2.4.2 Mandatory Assignment

When physicians accept assignment, there are certain criteria and requirements they have to meet. Becoming familiar with the services Medicare covers will save you time and effort when dealing with denied claims. Keep in mind that the requirements for claim filing should be followed all the time; if the requirements are not properly followed, providers may be subject to civil penalties of up to \$2,000 for each violation and/or Medicare exclusion. When a provider renders services to Medicare patients, money should only be collected at the time of service. If it is known that the service is not covered and the patient signs an ABN Advanced Benefit Notice, the patient knows the services that will be provided are not a covered benefit and the financial responsibility falls to the patient. There is an online billing service called TransactRx which will detail any patient's responsibility for certain vaccines that should be paid at the time of service.



Key Questions to Consider about Medicare

Should my Clinic accept assignment?	What are the advantages vs. the disadvantages of accepting Medicare assignment?
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2.4.3 Medicare and Vaccines

Health departments are aware that immunizations are the best way to prevent disease and maintain a healthier lifestyle, and knowing that our elderly are immunized and protected will offer peace of mind to our community. Medicare adheres to the Advisory Committee on Immunization Practices (ACIP) guidelines for immunization recommendations. Medicare understands that when persons are 65 years or older and/or have a chronic disease, it is recommended that they receive the pneumonia vaccine, in addition to their annual influenza vaccine.

Medicare Part B only covers pneumonia and influenza vaccines or vaccines related to treatment due to an injury or direct exposure, such as Tetanus (Tdap). Any other non-covered vaccines should be billed to third party payers, if applicable. Providers must remember not to collect any money in return for services rendered.



A. Medicare Specific Billing Requirements

1. G Codes

G codes were developed by the Center for Medicare and Medicaid Services (CMS) to represent the administration of a vaccine. Some of the applicable G Codes you will see in public health immunization billing (especially if doing outreach flu clinics) are:

- G0008 – Administration code for Influenza vaccine.
- G0009 – Administration fee for Pneumonia vaccine.
- G0010 – Administration fee for Hepatitis B vaccine.

2. Q Codes

Q codes represent the vaccine administered. Some of the applicable Q codes used for Influenza vaccinations are:

- Q2034 – Influenza vaccine, intramuscular
- Q2035 – Influenza vaccine, 3 yrs >, intramuscular

It is important to note that CMS often changes/updates these codes annually, so make sure you either have subscribed to the CMS newsletter (available as e-mail alerts) or check their website before billing for your annual flu vaccine outreach.

B. Advanced Beneficiary Notice (ABN)

The Advanced Beneficiary Notice (ABN) is a report given to Medicare beneficiaries to let the patient know Medicare is not likely to pay for certain services. The notice must be given to the patient before services are performed.

C. Part D Plans

Medicare Part D plans are offered through private insurance carriers who administer the plans in conjunction with Medicare to offer members drug coverage benefits not otherwise covered by Part A or B. There are great advantage plans for Medicare Part D prescription plans. Most offer good coverage with a low monthly premium, but not unlike private insurance, the coverage for vaccines can and does vary so, it is up to the member to do their homework when choosing a plan.

Some local Nevada Part D plans are:

- **Sierra Health & Life's** Sierra Spectrum, Sierra Nevada Spectrum, or Sierra Optima is a Medicare Advantage Private Fee-for-Service plan. Prime Health, Prime Plus, Premier Health and Nevada Select are Medicare Select Supplement plans that are more available to Southern Nevada members.
- **Hometown Health's** Senior Care Plus
- **Health Plan of Nevada's** Senior Dimensions

Other carriers, such as BCBS, also offer these Medicare HMO or PPO products, so you will need to decide whom to contract with to ensure maximum payment for your services.

2.4.4 Billing Method Options

There are several ways to bill Medicare and a lot depends on what you will be billing for; however, you will need to do it through the Medicare Administrative Contractor, or MAC. A MAC is a private organization that carries out the administrative responsibilities of Traditional Medicare (Parts A and B). In other words, they process claims for Medicare. The MAC for Nevada currently is Noridian. Visit this link for more information and access to the provider portal Endeavor:

<https://www.noridianmedicare.com/>.

If you are only billing as a Mass Immunizer (billing only for flu and pneumonia clinics), you can choose the Roster billing method. If you are billing for all clinic services or only vaccines for clients coming into your clinic, you will need to bill using the standard CMS 1500 form. The following is an overview of the methods of claim submission to Medicare.

A. Roster Billing (Influenza / Pneumococcal Vaccinations Only)

Another option to billing Medicare for flu and pneumonia vaccines is to use the Roster Billing form. This option is very efficient during flu/pneumonia season or while performing community health clinics. The form on the next page, along with a sample roster form, includes the information you will need to bill, such as the insured's ID Number, Patient Name (Last, First Middle Initial), Patient Address (Number, street, city, Zip code), Patient Date of Birth, Patient Sex, and the signature. If you do not get the patient signature but you have it on file, you can put 'signature on file' in the box.

There is a specific form for both influenza and pneumonia, so be sure to use the correct form. The HCFA 1500 will need to accompany the roster of flu or pneumonia vaccines given. Remember, you CANNOT submit flu and pneumonia together. Also, the limit is 10 rosters accompanying one CMS 1500 form.

Once Medicare receives the form, the data is manually entered and payment will be made once all patient claims are processed.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

<input type="checkbox"/> FICA <input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDIGAD <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA BENEFIT <input type="checkbox"/> OTHER										1a. INSURED'S ID. NUMBER (For Program in Row 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) See Attached roster										3. PATIENT'S BIRTH DATE MM DD YY									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. INSURED'S DATE OF BIRTH MM DD YY									
6. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE										7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE									
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										9. EMPLOYER'S NAME OR SCHOOL NAME									
10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment below.										11. EMPLOYER'S POLICY OR GROUP NUMBER NONE									
12. DATE OF CURRENT ILLNESS OR INJURY (Please check one) <input type="checkbox"/> 1. I have a new illness or injury. <input type="checkbox"/> 2. I have a pre-existing condition that has become acute. <input type="checkbox"/> 3. I have a pre-existing condition that has become chronic.										13. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE FIRST DATE MM DD YY									
14. DATE OF CURRENT ILLNESS OR INJURY (Please check one) <input type="checkbox"/> 1. I have a new illness or injury. <input type="checkbox"/> 2. I have a pre-existing condition that has become acute. <input type="checkbox"/> 3. I have a pre-existing condition that has become chronic.										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE FIRST DATE MM DD YY									
16. NAME OF PROVIDING PROVIDER OR OTHER HEALTH CARE PROVIDER 17. RESERVED FOR LOCAL USE										18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. HOSPITALIZATION DATES (RELATED TO CURRENT SERVICES) FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please check one) <input type="checkbox"/> 1. I have a new illness or injury. <input type="checkbox"/> 2. I have a pre-existing condition that has become acute. <input type="checkbox"/> 3. I have a pre-existing condition that has become chronic.										22. OUTSIDE LAB \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
23. MEDICARE RESUBMISSION CODE OFFICIAL USE ONLY										24. MEDICARE IDENTIFICATION NUMBER									
25. FEDERAL TAX ID NUMBER <input type="checkbox"/> SSN <input type="checkbox"/> EIN										26. PATIENT'S ACCOUNT NO.									
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING NUMBER OR CREDENTIALS (I verify that the statements on the reverse apply to this bill and are made in good faith.)										28. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING NUMBER OR CREDENTIALS (I verify that the statements on the reverse apply to this bill and are made in good faith.)										30. TOTAL CHARGE \$ 0.00 31. AMOUNT PAID \$ 0.00 32. BALANCE DUE \$ 0.00									
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING NUMBER OR CREDENTIALS (I verify that the statements on the reverse apply to this bill and are made in good faith.)										34. PROVIDER FACILITY ADDRESS INFORMATION Carson City Community 900 E. Long St. Carson City NV 89706									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0935-0899 FORM CMS-1500 (06-06)

Number	Insured's ID Number	Patient's Name (Last, First, MI)	Patient's Address (Number, Street, City, Zip Code)	Patient's Date of Birth	Patient's Sex	Patient's signature or "signature on file"
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						
11						
12						
13						
14						
15						

For Pneumococcal Pneumonia Virus Vaccine Roster:

Warning: Ask beneficiaries if they have been vaccinated with PPV.

- Rely on patient's memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine.
- If patients are certain they have been vaccinated within the past 5 years, do not revaccinate.

B. CMS-1500 Instructions

There are certain fields that can be preprinted on the CMS-1500 form for Medicare Submission when submitting along with a Roster:

Field 1: Medicare

Field 2: See Attached Roster

Field 11: None

Field 20: No

Field 21: V04.81 for Influenza or V03.82 for pneumococcal

Field 24B: Enter 60 (POS Code 60= Mass Immunization Center)

Field 24D: Enter appropriate vaccine and administration codes

Field 24E: Enter 1 for lines 1 and 2

Field 24F: Enter the unit cost for the appropriate vaccine

Field 27: Enter Yes

Field 29: Enter \$0.00

Field 31: Signature Field

Field 32: Enter name, address, including zip code, of the location of where the service was provided

Field 32a: NPI of the service location

Field 33: Provider Identification Number (NPI) when required

Field 33a: NPI of the billing group or provider

C. Electronic Billing

If you choose to submit claims electronically, you will need to meet Medicare's guidelines and standards. You must submit claims electronically via EDI in the HIPAA format, except in limited situations. Complete the Electronic Data Interchange (EDI) Enrollment Form and send it to your designated MAC prior to submitting EMCs. A submitter number, which is required to submit electronic claims, will then be issued. An organization comprised of multiple components that have been assigned more than one Medicare provider identifier may elect to execute a single EDI Enrollment Form on behalf of the organizational components.

Claims are then electronically transmitted to the MAC's system (in Nevada's case, Endeavor), which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-pass edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may be:

- returned to you for correction;
- suspended in the MAC's system; or
- corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to you. This report also indicates the claims that have been rejected and reason(s) for the rejection.

D. Electronic Media Claim (EMC) Submission Alternatives

If you do not submit electronic claims using EMC, you may alternatively choose to submit claims through an electronic billing software vendor or clearinghouse, billing agent, or Medicare's free billing software. You can obtain a list of electronic billing software vendors and clearinghouses, as well as billing software, from your MAC. One such electronic billing service is TransactRx.

1. TransactRx

TransactRx is a widely used billing service that processes claims for vaccines for providers. By putting in the patient's information, the software communicates directly and in real time in order to determine how much the physician will be reimbursed and how much the patient is responsible for before the vaccine is administered. TransactRX will allow staff to process a claim for all or partial reimbursement of a vaccination and administration fee. It processes Part B for influenza and pneumonia and Part D prescription plan for other covered vaccines. It is important to note that currently this billing software does not process claims for other healthcare services. Providers must register and give access to authorized staff members who will be in charge of processing claims. For more information on TransactRX, including how to contract with them follow this link:

www.transactrx.com.

2. Paper Claims

In limited situations, you may submit paper claims to Medicare. To find out more about paper claims go to: <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html> for more information.

Overall, it may be a good idea to contract as a Medicare provider, depending on your client base. Most public health departments will see that it is a lucrative venture to at least contract to provide vaccines, especially influenza and pneumonia.

2.4.5 Medicare Advantage Plans

A Medicare Advantage Plan is a plan offered by a private company that contracts with Medicare to provide Medicare Part A and Part B benefits. Medicare services are covered through the Advantage plan and are not paid for under Original Medicare benefits. Patients must be enrolled in the Advantage plan, even though they still have Medicare. They can only enroll in an Advantage plan during certain times of the year.

They must follow plan rules, such as getting a referral to see a specialist to avoid higher costs if the plan requires it. The specialist must also be in the plan's network. If they go to a doctor, other healthcare provider, facility, or supplier that doesn't belong to the plan's network, services may not be covered or costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs. Providers can join or leave a plan's provider network anytime during the year. The plan can also change the providers in the network anytime during the year.

Medicare Advantage Plans can't charge more than Original Medicare for certain services, such as chemotherapy, dialysis, and skilled nursing facility care. Medicare Advantage Plans have a yearly limit on out-of-pocket costs for all medical services.

2.5 Private Health Insurance

Establishing billing relationships with private insurances can have a significant impact on a health department's bottom line, as well as enhancing the capability to support the overall health and wellbeing of the community. In the survey conducted throughout Nevada health departments in early 2012, a general consensus was established of the private insurances held by their clients. This type of inquiry is strongly suggested, since it not only provides you with the top insurances represented but can also give you an approximation of how many in each insurance group. This information, albeit rudimentary, can be instrumental when negotiating contracts, as insurance providers want to ensure their clients are able to continue to seek care.

Public health department have been reticent to contract with private providers for several reasons.

Some of the top reasons expressed during this project were:

- 'We don't want to compete with the private sector'
- 'If the private insurance companies don't reimburse 100% of our charges, we will lose'
- 'The contract is legally too prohibitive'
- 'Who can afford to purchase all those private vaccines in the hope that insured clients come to our clinic?'

All of the above are valid considerations; however, more importantly, your organization should consider these questions as well:

- What are your billing priorities?
- Who do you want to contract with?
- How many plan members are seen in your clinic?
- Which programs or services do those clients utilize?
- What experiences have other health departments had in contracting with this provider?
- Are the proposed reimbursement rates adequate to cover costs?
- Can your health department manage the time lag for reimbursement? (Which is generally 31-60 days from billed claim to paid)
- Are there disadvantages to contracting? Do the benefits outweigh the disadvantages?

Once it's been determined whether contracting with a private insurance will be beneficial to the health department, consider becoming an "in-network" provider to contract with one or more of the most common plans. Contracting may not be the best option if there are not enough clients coming in with that particular insurance. This is something each health department must decide.

2.5.1 Provider Service Representative

It is important to develop at least one key contact in Provider Relations, Health Plan Quality Assurance, or the Claims Management Department who can help streamline the process efficiently for you. The private insurers have contracting specialists whose job it is to assist providers with contracting. As was mentioned earlier, this contact information can generally be found on the insurance plan's website or by calling the general contact number.



Key Questions to Consider

Will the benefits outweigh the costs? Is it worth the time and man hours?	Do we want to bill all, or only a select few, private health insurance carriers?	Do we want to bill for only certain services (i.e., vaccinations) or all?
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2.5.2 Becoming an In-Network or Preferred Provider

Once your organization has decided to contract with private insurances and you reach out to the contracting specialist (with the letter of intent), it is a good idea to keep track of the contracting and credentialing process. This is generally only a small part of your job, but it is important to follow up. The document on the next page can be an effective tool to ensure proper and timely follow-up on what can be a daunting process. (*This is also found in the Forms and Templates section of this manual*).

Provider/Clinic Responsibilities

It is important to understand that all insurances do NOT have the same contract language, but most have the same categories they cover. The following is an overview of what you can expect to see in a typical private insurance contract. It is a good idea to begin the conversation with your administration in anticipation of these requirements.

1. Claim Submissions
 - a. Where do they want the claims sent to?
 - b. How do they want claims sent – via paper, electronically or either?
 - c. What is the timely filing deadline (in other words how long do you have to submit a claim after the date of service)?
 - d. What type of form must be used (usually a CMS 1500 if by paper or an ANSI 837 version 5010 form (have your IT department set this up)
2. What are the on-call or hospital admission/privileges requirements (if any)?
3. What is the appeals process?
4. What do you need to obtain a prior authorization for and what is the process for doing so?
5. What do you have to do when making a referral? Does it have to be to a provider on the patient's plan?
6. What are the liability and malpractice insurance requirements?
7. What do you have to do when you receive an overpayment? Or underpayment?
8. What are your requirements for cooperating with their utilization review procedures (many insurances send inquiries periodically for data that must be returned in a timely manner)?
9. What is the term of the agreement?
10. What is your obligation if you wish to break the contract?

As you can see, the contracting process can be quite daunting ,but if you know what to expect and also that the language is there to protect the insured and the organization, as well as the insurance company, it should be reasonable to work through.

Once the contracts are signed, it is a good idea to keep track of the different requirements in a spreadsheet in order to follow up with each in the future. The following matrix can be used.

Payer	ABC Insurance	XYZ Insurance	Medicare
Timely Filing Deadline			
Submission (paper vs. Electronic)			
Prior Authorization			
Credentialing Requirements			
Term of agreement			
Appeals Process			

These are the main categories that you will need to be most familiar with to do your billing, but you can always access the contract or call the contracting specialist for specific questions.

By this point many of you are thinking this process is too daunting and time consuming for my staff to be able to handle it. The reality is that most public health departments, if billing at all, have historically utilized administrative assistants with little or no prior billing experience. When considering expanding out to contracting with private insurances, many have decided to hire an experienced biller. There have been others that chose to outsource or hire a billing company to do their billing for them. The next section will examine both options in more detail.

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2.6 Outsourcing vs. Hiring an Internal Biller

Outsourcing

If you decide it is cost prohibitive to hire someone to do your billing, you may choose to outsource or pay a billing company to do it. It is important to realize that not all billing companies work the same way; some work locally while others work nationwide and not all provide the same services. Some may just process claims, whereas others offer more in depth revenue cycle management tools. There are also a few that offer all services needed to get you ready to begin billing, including credentialing and contracting. Finding the appropriate billing company can be very challenging and requires extensive research to find one that suits your specific needs.



2.6.1 Outsourcing of Credentialing

Billing companies that offer credentialing services will most likely charge a fee for this and the fee is determined by the extent of credentialing services to be provided. For instance, a public health agency going to be PAR (participating) with Medicare, Medicaid, and Blue Cross will not have the same fee as if they were to be credentialed with all insurance companies.

At the time of outsourcing credentialing, the public health staff will be required to either complete the Universal application or just order provide the credentialing company with the necessary information to process the application. The public health agency will also need to provide all copies of the necessary supporting documents, such as medical licenses, controlled substance licenses, medical school diploma(s), CLIA certificates, and any other information that pertains.

Once the outsourcing company completes the applications, original signatures will be required. Some forms will need to be signed by the medical director or providers, while other documents will need to be signed by the Department Director.

Outsourcing credentialing can be very beneficial for the public health staff by saving staff time and therefore money; however, it can be quite expensive. Depending on the scope of practice, the cost to credential a single provider for all insurances, including Medicare and Medicaid, can be anywhere from \$1,500 to \$2,000. Remember that the fewer insurance companies credentialed, the lower the price will be.

It may be challenging to find a company that provides only credentialing services, when the public health agency wants to do their own billing. This is because most billing companies provide

credentialing services only to the agencies they have a billing contract with. The billing company can choose to provide credentialing services without billing, but the cost will most likely be higher.

CAQH (Council for Affordable Healthcare) is a credentialing company that puts the cost on the carrier interested in contracting with you. Unfortunately, they are not credentialing APNs, RNs or clinics at this time. However, this will most likely change as public health plays a larger role in the Affordable Care Act, so be sure to sign up for updates or give them a call each quarter to see if they have any new information.

2.6.2 Outsourcing of Billing

If you have limited staff or other time constraints, you can choose to hire a billing company to perform your billing for you. When selecting a billing company, the public health agency needs to provide full disclosure of its operations. The billing company needs to fully understand how your clinic/agency works. You want a billing company with experience and/or knowledge of the special nuances of public health, (i.e., working with grants and clients with economic challenges) especially the atypical healthcare model of nurse practitioners providing care in the absence of a medical doctor on site at all times. Services provided are vital for planning, developing and budget for the billing company. A good relationship needs to be maintained between the billing company and the public health agency in order to be successful.

To be most helpful to your organization, billing companies need to be able to handle the following tasks, in order of preference:

- Standard CMS 1500 claim processing, including charge entry and electronic claim filing
- Claim follow-up, re-bills and appeals for payment
- Filing secondary claims
- Handling telephone inquiries
- Conducting follow-up activities
- Sending patient statements (you may want this as a higher priority)
- Providing informational reports
- Superbill development
- Working with a collection agency

For the best experience, you should be familiar with the staff working on your account and also ensure there is acceptable back-up coverage when they are not available. If there are any delays in processing claims, this will have a direct negative impact on cash flow.

Another important point is to find out how often the billing company submits electronic or paper claims. Some companies submit once or twice a week, while others submit claims daily. Determine if they file directly to Medicare, Medicaid or Blue Cross; keep in mind that small billing companies may not file directly with payers. This will greatly impact reimbursement times as well.

The billing company should be able to provide financial reports for the public health agency to review. These should include, but not be limited to, amount billed, reimbursements, days in Accounts Receivable and total revenue. Most of these reports can be obtained electronically; some billing companies may charge a fee for printed reports.

Payment Posting

Once the payer processes the claim and sends payment, the billing company will receive all electronic files or 835s, which will open the detail of payer EOBs. The billing company will post all payments, non-payments and patient balances, as well as deposit all EFT payments into the organization's bank account of record, unless you set up your own EFT, which allows an even faster turnaround.

Cost

There are different ways in which a billing company can price their services. Many billing companies charge a percentage of payments posted in patients accounts. (At the time of this printing the average industry rate is 7% of monies received). This includes co-payments and other payments collected by the public health agency staff. These companies are motivated to do a good job for you because the more money they are reimbursed, the more the company makes.

The percentage charged will usually be based on a sliding scale, and billing companies working for clients where the patient fee is large, like a surgeon's practice, the percentage will be high. That way the billing company can make enough revenue to cover their costs.

Other billing companies charge per claim submitted. This is a better way to determine what the service cost will be and thus might be an easier way for the public health agency to budget.

Some additional services a billing company might provide are:

- 1) Coding Services
- 2) Insurance Verification
- 3) Management Consulting or Practice Management Services
- 4) Credentialing
- 5) Remote Access to your EMR to Bill

It is highly recommended to interview several billing companies, since this is the best way to find one that will meet the individual needs of your public health agency. Compare each of the billing companies and find references. Once you know which billing companies will meet your needs best, solicit a list of clients and then call the clients to find out how the billing company is working for them.

When the contract is established, it will clearly need to state the agreement details and responsibilities of both parties. Then it will need to be signed by both parties. There should be a clause stating any early termination penalties by either the billing company or the public health agency. In any case, if the contract is terminated early, there should be a clause explaining the next steps and whether the billing company should continue to collect payment on outstanding accounts until both parties agree otherwise. This may take up to six months.

Medical billing companies are unique business partners, and to be successful it requires incorporation of all the public health agency's activities to ensure accurate coding and claim submission. If the billing company is not operating as a trusted partner, there are risks related to compliance and overall success of the billing process.

The following table may provide you with a guide to assist with making a decision on which option is right for your organization.

Comparison Chart	Internal Billing	Outsourced Billing
Billing department costs	\$	\$
Software and hardware costs	\$	\$
Direct claim processing costs	\$	\$
Software and hardware costs	\$	\$
Collections costs	\$	\$
Collections, net of costs		



Key Questions to Ask

- Are charges based per claim, line item on claim or percentage of reimbursement per month?
- Are there additional “overhead” charges (staff training, clearinghouse fees, etc.)?
- What kind of month-end and year-end reports can we expect with our contract? Is there an extra charge for additional reports, if necessary?
- Is the billing company insured in case of legal issues? For example, bad claims, fraud, etc.
- How often are rates increased? Annually or quarterly?

If you decide to proceed with an internal billing process, you will need to develop policies and procedures and job descriptions for all involved. The next section is meant to be a guide in doing so.

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2.7 Processes

2.7.1 Front Desk Reception

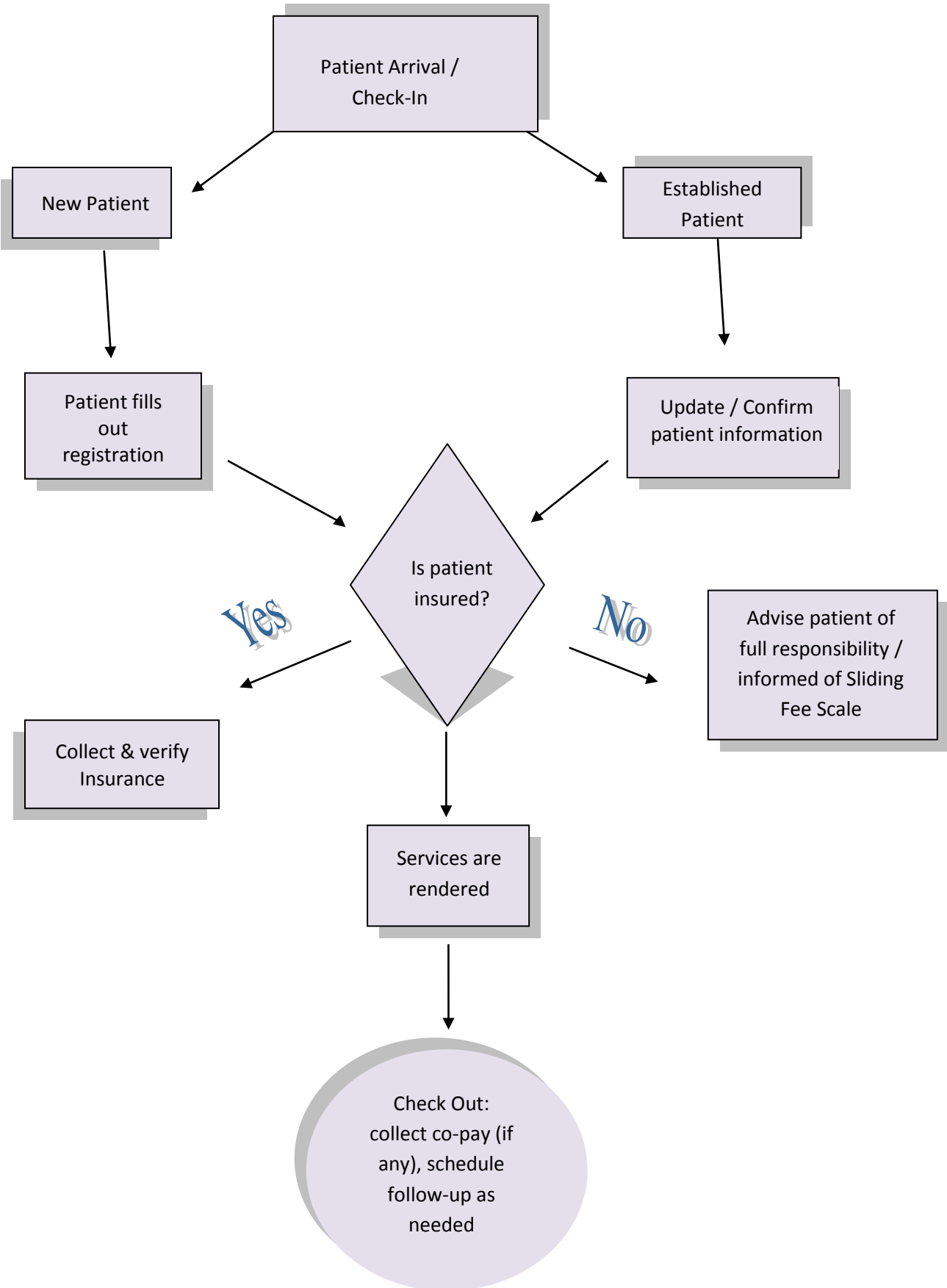
The front desk receptionist or administrative assistant is the first person your patient sees when they come to the clinic so it is imperative they be informed on all aspects of billing from start to finish. Even though they will not be doing the actual billing, they play an integral role in obtaining the information needed to bill correctly the first time. One of the most important methods of capturing the necessary billing data is to have a standardized demographic form. This form must contain certain information in order to bill.



Key Pieces of Information the Front Desk Should Collect

- Patient's name, address, DOB & phone
- A photocopy of the patient's insurance card, front and back to capture the payer's name, identification number, group number, and mailing address
- If client is not the insured, collect the policy holder's name, date of birth, address and ID numbers

The next page shows a typical front office/receptionist role in a clinic visit.



Front Office Process Detail

Besides being the first person the patient sees, the reason the front office staff plays such an important role is that without the correct information documented from the first encounter all the billing and communications (letters, notices, statements, etc.) will go to an incorrect address, insurance or all of the above.



Key data to make sure you ask and get correct:

- Do you have insurance or another payer source? (For example, some people don't consider Medicaid as insurance, or there is also Women's Health Connection or Access to Healthcare Network)
- Who is the insurance through, such as the spouse's work, your parent or your own? or Who is the guarantor (but patients don't usually know this terminology)
- Are you new to the clinic? (Your EMR should show this...patient has to be seen within 3 years)
- Do you have a co-pay or high deductible (only if you choose not to do eligibility checks)

Also, keep in mind the address on the back of the insurance card: WHERE TO MAIL CLAIMS is the address that you will bill. Always double-check your insurance ID, name, and date of birth, which are the three most common errors on claims!

Eligibility Verification

When a patient presents with an insurance card, it is a good idea to check their eligibility to receive services. You have a few different options for checking eligibility. You will need the patient name, date of birth, ID number, and guarantor name and date of birth, at a minimum, but some websites require more and some less.

Availity™ is a free online tool to check client's insurance eligibility. To log on to Availity™ go to: <https://apps.availity.com/availity/web/Home>. This system has the ability to check multiple carriers for eligibility and claims data, including Aetna, Anthem BCBS, Cigna and Humana currently. Updates

occur frequently, so it is worthwhile to check the website to see if it will be a benefit to your clinic. Other carriers' websites also offer eligibility verification and some also offer access to claim information and the ability to submit a request for prior authorization. (Avality™ is one that does).

Smaller insurance carriers (or self-insured employers) may require a telephone call to check a client's eligibility and a faxed form for prior authorization. It is good practice to create a binder as a resource for the receptionist and biller that details the preferences of the carriers you are contracted with.

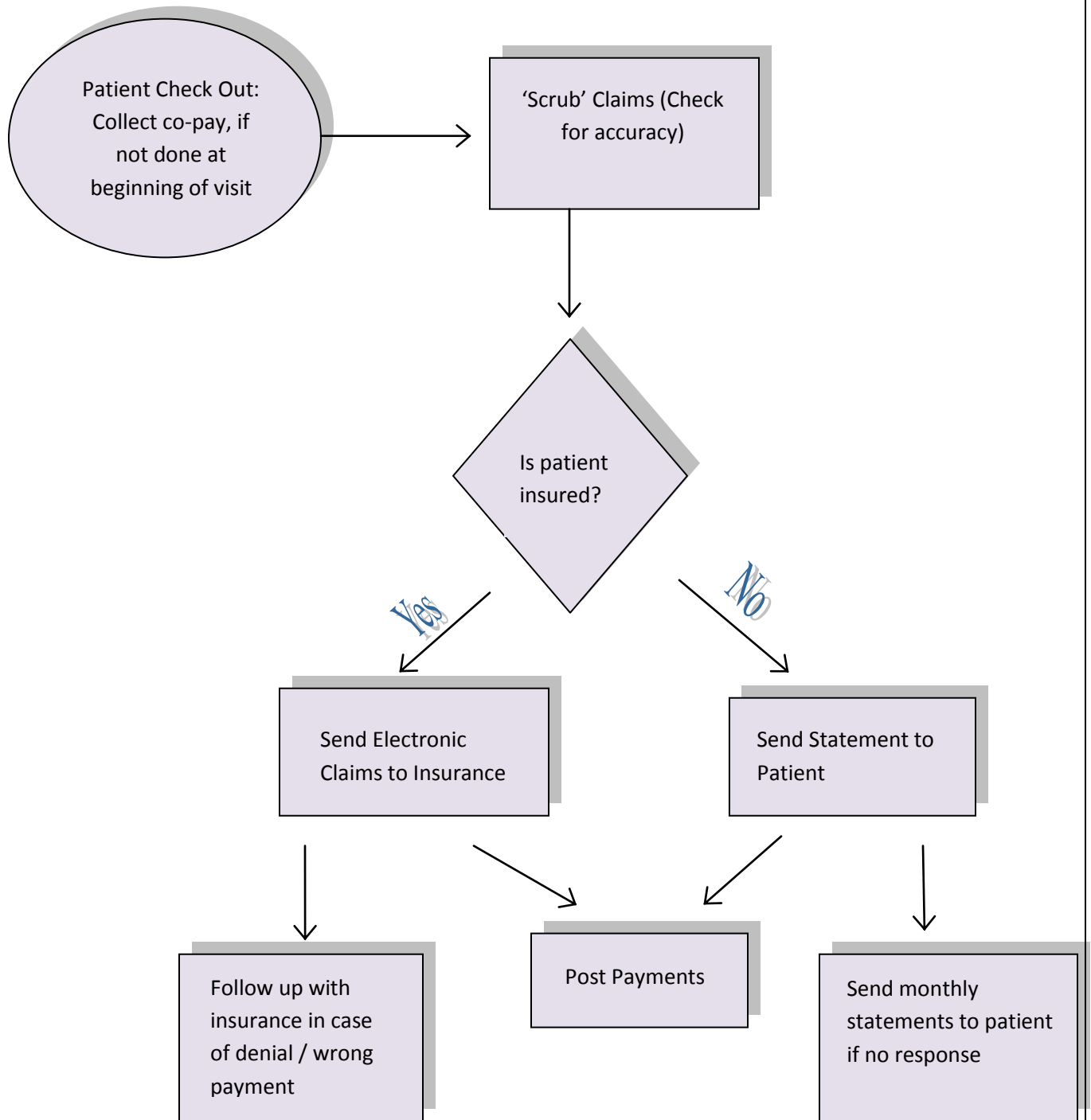
2.7.2 Back Office Process

Once the patient has been checked in (whether you have an EMR or not) they will need some sort of superbill or encounter form for the provider to document (in CPT and ICD-9 codes) what the billable charges are. This can easily be created from your fee schedules (*see samples in Resources Section*). The providers will need to be trained in proper documentation for the codes they are charging for. There are many online webinars available to provide this training (several from the American Medical Association).

Billing Process

Now that the patient has made it through the clinic visit, the billable charges are either entered in the EMR or written on the super. The appropriate co-pay or co-insurance has been collected and the billing process begins. It is preferable to have some sort of billing software that will automatically calculate the adjusted rate after the insurance payment and patient co-pay is entered. This is important for several reasons, two of which are to avoid the possibility of mathematical errors and the other to be able to provide reports of billed and collected amounts.

The next process diagram explains a typical billing process.



Billing Processes Detail

A. Checkout

- The co-pay or co-insurance information is either found on the patient's insurance identification card or when checking eligibility on the website
- Make sure to provide the patient with a receipt

B. Biller

Scrubbing claims is defined as reviewing the claim for accuracy: is the identification number entered? Are there any hyphens, number signs or other symbols in the patient demographics?

(These are generally not accepted in the claims process.)

- Are the codes (CPT and ICD-9, along with any applicable modifiers) appropriately assigned? (Remember that if there is a question regarding a code, you must go through the provider to change it, you cannot change their documentation)
- Is the provider's name and NPI on the claim?
- Is the documentation complete? (For example in the case of an immunization, has the provider/nurse documented the vaccine, where and when given, and the appropriate codes)?
- Is the correct insurance chosen? (Name, address and, if using a clearinghouse, the payer ID number)?
- If the patient has Nevada Medicaid, does the ID number have 11 digits?
- Is the guarantor name and date of birth written and attached to claim?
- Is the correct relationship chosen (i.e., for Medicaid it is ALWAYS self, but for private insurance it may be the parent, spouse, etc.)?

As you can see, the billing process is very dependent on correct data entry, so a good attention to detail is vitally important. This is something to keep in mind when choosing a candidate to be your biller.

Claim Denials

As was stated earlier, not all claims will be paid; actually if you are new to the billing process it may seem many are not. It is important if you see this happening to contact the insurance provider relations specialist for more education and explanation on what it is that you are doing incorrectly (or which is often the case, there is not a reason and the claim may have been denied in error).

Sometimes the payer's system needs a code loaded correctly or there is another type of error in their system.



Claim Denial Lessons Learned

- If there is a new Vaccine or other CPT code, make sure the payer will cover it and it is loaded in their system (otherwise it will be denied in error)
- Make sure you are signed up to receive notices from all insurance carriers you are contracted with (when they make changes to how you should be submitting claims, they will often notify providers via e-mail)
- Make sure you know the correct process for when to appeal vs. when to re-submit a claim

Some of the above lessons were unfortunately learned the hard way with a loss of claim reimbursement that could not be regained. It is important to note that ignorance is not bliss and the insurances expect you to do your due diligence prior to submitting claims...in other words, do it right the first time!

Claim Follow-up

It is equally as important to create an organized system (be it in folders or in the electronic medical records system) for follow-up on the claims that either need to be re-submitted or appealed because you are still working under timely filing deadlines. If you choose to organize your follow-up claims by folders, you may want to have a folder for each payer with their timely filing deadline requirements on the front as a reminder. You can then put the claim copies in order by date, with most recent in back and oldest in front as a way to prioritize.

If you have an electronic medical record or practice management software, you will need to work with your software support personnel to create the best system that will work for you.

Reports

Another critical component of a successful billing program is tracking revenue and spending as it relates to patient accounting and billing. There are many different possible reports that your organization may choose to collect for review, but the following are some of the most common and best practices in the medical billing industry.

Management and Administration

1. Income and Expenses
 - a. Staff Expenses
 - b. Supply Costs
 - c. Overall Income
2. Productivity Reports (usually found in the Practice Management software or EMR) including:
 - a. Total Charges
 - b. Total Receipts
 - c. Total Adjustments
 - d. Total Uncollected Balances/Write-offs
3. Patient Visits
 - a. How Many
 - b. What Payer Source
 - c. What Type of Visits
 - d. How Many No-Shows (lost revenue)
4. Accounts Receivable Reports (follows how much money is owed to the organization and how long it is sitting unpaid)
 - a. Should Be Run Monthly
 - b. Industry Standard is: total amount should be approximately 1.5-2.5 months' worth of charges and amount sitting over 90 days should not be > 15% of total accounts receivable

While these are the guidelines for reports, they are just that, guidelines. Your organization will need to examine what are the most important reports for your biller to run. Also, with the uniqueness of public health having so many different funding sources, such as grants, and state and county funds, these sources of income will need to be accounted for and designated according to the specific grant or governing body's requirements.

Quality Assurance and Improvement

Another important concept to consider when getting started is to create tools that will measure and monitor quality assurance and improvement. Many do not feel this particular component is important, especially when the rest of the billing process can be so overwhelming. If you set these guidelines prior to beginning, it assures you a means of monitoring your successes and also places where you need to improve. Keep in mind all Quality Assurance and Improvement Tools can be adjusted as you grow. On the following pages is an example of a QI tool developed to monitor the accuracy of data entry from the front and back office, along with other facets that are important to 'doing it right the first time.'

It is a good idea to have someone that understands the billing process assigned to do the chart review. It is up to you if you choose to do it monthly or quarterly, but make sure you share the results with your staff so they can learn from the errors and positives from their peers. It is also recommended not to have the specific employee information included in the discussion, but as a manager or administrator you will probably want to keep the results for follow-up with the individual staff member.

Billing QI Audit Tool

Patient ID Number (#) _____

New Patient _____ Established Patient _____

Age _____

Visit Type _____

FRONT OFFICE				
Auditor Initial	TOPIC	QUESTION	Comments	Corrective Action Needed
	Fee Schedule	1. Is the correct fee schedule chosen?		
		2. Does the tier match the income verification form?		
		3. Does the income verification on the form match what is in the chart (i.e. is the math correct)?		
		4. If the client has AHN, is the correct tier in the computer?		
	Insurance Information	1. Is the information up to date (within 12 months of last visit)?		
		2. If insurance was termed, is it termed in the chart?		
		3. Is the guarantor information correct?		
		4. Is the correct Medicaid option in the chart (NV CK up, HPN, Amerigroup, MCD)?		
		5. Do the insurance i.d numbers match what is on the card?		
		6. Is the correct address chosen for where to mail the claims?		
		7. For WHC clients, is the stamp on the receipt correct identifying the amount which is their responsibility to pay?		
	Demographics	1. Is all required information in the chart? i.e., name, address, telephone, responsible party		
		2. Are there any #, dashes, commas in the address?		
	Co-Pays	1. Is the co-pay put in (under insurance information)?		
		2. Is the amount collected put in correctly?		
	Document Handling	Are the following documents scanned in chart?		
		1. Insurance card (if applicable)		
		2. Registration forms		
		3. Income verification form		
		4. Receipts		
BACK OFFICE				
	Coding	1. Is the correct ICD-9 matched to the CPT code?		
		2. Is the correct vaccine administration fee code applied?		
		3. Is the correct vaccine type chosen?		
	Miscellaneous	1. Are send out labs on the superbill for insured clients?		

APPENDICES

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3.1 Glossary

835, 835 Download – a HIPAA-compliant downloadable file for third party reimbursement payments. The 835 file system contains an Explanation of Benefits (EOB) and an Electronic Remittance Advice (ERA) electronically by batch mode

A

Acknowledgment of Notice of Privacy Practices – a notice that informs patients of any privacy concerns and prompts them to discuss their healthcare questions. The NoPP defines how medical information about the patient may be used or disclosed and how the patient can access their information. This is a standard part of the patient registration process.

Advantage Plan (Medicare) – a plan offered by a private company that contracts with Medicare to provide Medicare Part A and Part B benefits. Medicare services are covered through the Advantage plan and are not paid for under Original Medicare benefits and patients must be enrolled in the Advantage plan.

Affordable Care Act (ACA) – the federal Patient Protection and Affordable Care Act (PPACA) signed by President Obama on March 23, 2010, whose goal is to provide healthcare to about 32 million currently uninsured Americans by expanding both private and public insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the healthcare workforce, and curb rising healthcare costs.

Allowable Amount – a schedule of maximum allowable amounts that are billable to third party payers on services that are specified in the payer's contract with a provider.

Allowable Services – medical services provided for payment by a specific medical insurance company or government health plan.

American National Standard Institute (ANSI) – a not-for-profit organization, founded in 1918 that assists with assuring the safety and health of consumers and the protection of the environment by setting standards and guidelines for many industries, including healthcare. In the medical billing industry, it is used in context with listed standardized forms (*ANSI 835 and ANSI 4010A1*).

ANSI 835 – a standardized downloadable EOB. Requires prior registration with payers and may require specialized software. The ANSI 835 is not available from all payers.

ANSI 4010A1 – a standardized claim form commonly used with medical billing software

ANSI 5010 – American National Standards Institute standardized electronic medical claim form that accommodates ICD-10 codes. Per CMS, all covered entities must be fully compliant with the 5010 on January 1, 2012. ICD-10 codes must be used on all HIPAA transaction on and after October 1, 2014.

Appeal – to request a denied claim to be reconsidered by the third party payers.

Advanced Registered Nurse Practitioner (ARPN) – a Registered Nurse (RN) who has advanced education and clinical training in a healthcare specialty area, an APN can diagnose and prescribe medications to patients.

Assignment of Benefits – the transfer of reimbursements by the third party payer to the medical professional delivering the allowable medical service.

Authorization to Treat – an authorization form signed by the patient or responsible party for the healthcare provider(s) to administer treatment to the patient. (*Synonym: Consent Form or Consent to Treat Form*)

B

Balance Billing – to bill patients for the difference of cost of service provided and what the healthcare plan pays.

Beneficiary – a person who is qualified to receive healthcare under the policy holder covered by the health plan (spouse and/or children). Coverage may be dependent on specific criteria under the health insurance plan.

Benefits – services covered by a health insurance policy or program to the policy holder or beneficiaries. Benefits differ from plan to plan and should be reviewed by the policy holder. (*Synonym: Insurance Benefits*)

Billable Services – billable services provided to patients that are considered for payment from private or government insurance plans. (*Synonym: Allowable Services*)

Billing Company – an organization which contracts for a fee with a healthcare provider(s) to provide all aspects of their billing needs and acts as a liaison between the provider and insurance company. (*Synonym: Medical Billing Company*)

Billing Software – electronic program that assists a company in compiling the necessary data for billing their clients, and is often included in a practice management module

C

Council for Affordable Quality Healthcare (CAQH) – Universal Provider Datasource (UPD), which is a nonprofit organization that promotes quality between providers, insurance agencies, and

stakeholders. The UPD simplifies data collection, credentialing process, reduction in administrative costs, claim processing, and quality assurance.

Claim Adjustment Reason Code (CARC) – a code which is used to report payment adjustments, and appeal rights to a claim that was paid differently than it was billed.

Centers for Medicare and Medicaid Services (CMS) – an administrative agency of the Department of Human and Health Services (DHHS) instituted in 1965; its purpose is to administer the Medicare prospective payment systems (PPS) and fee schedules, and also to perform quality control and review healthcare administered to Medicare recipients.

Certificate of Liability Insurance – used as proof of insurance for a business or company and describes in detail the insurance policy, including policy numbers; effective and expiration dates; and the name of the insurance company providing the coverage. (*Also known as the Insurance Certificate or Malpractice Face Sheet*)

Claim – a medical bill for services provided to the patient by the physician that is sent to a third party payer for reimbursement.

Clearinghouse – a public or private entity that links electronic claim information submitted by a payer to third party payers for reimbursement.

CMS 1500 – a standard paper claim form used by healthcare professionals (*previously called the HCFA 1500*).

Coinsurance – a policy provision where the insured individual and the insurance company share the total costs of the medical services as a fixed percentage but only after the deductible has been paid.

Collections – the activity of collecting an unpaid balance that is owed for medical services provided; can be a professional entity that specializes collection services.

Consent to Treat – is an authorization form signed by the patient or an authorized representative to authorize a physician(s) to treat the patient.

Co-payment – a fixed amount that is defined by the insurance policy defining the out-of-pocket expense for any healthcare services paid by the insured person at the time of service; can be a percentage or a flat amount.

CPT Codes (Current Procedural Terminology codes) – a list of codes published annually by the American Medical Association as the national standard code set for physician services; they are numerical codes consisting of five digits assigned to diagnoses, procedures and services.

Credentialing – the authorization or documentation of a healthcare professional or provider to a healthcare insurance company that verifies their licenses, education, and all other aspects of their professional career.

Curriculum Vitae, CV – professional history, including a summary of an individual’s accomplishments, academic realms, and employment history.

D

Deductible – an amount that is determined by a member’s insurance policy that must be paid before benefits begin.

Demographic – information regarding a patient’s identification that is collected by the facility where the service is provided and includes the patient’s name, date of birth, social security number, address and phone numbers; this information is used for providing billing medical services. (*See registration form*)

Denial / Denied Claim – a medical claim that has been submitted and was denied for payment by the third party payer.

Diagnosis Codes – codes used to identify patient’s diagnoses in the medical record; used in medical billing. (*See ICD-9 Codes*)

Donations – a term used in conjunction with hardship policies to allow receipt and recording of monies given by a patient towards any balance they have accrued. (*See Hardship Policy*)

Date of Service – the date that medical service was performed and is recorded in the patient’s record.

E

Evaluation and Management codes – codes that providers use to document a patient encounter in the medical record and for billing purposes; reflects the extent and level of service provided, including the time it takes to perform the service.

Electronic Data Interchange (EDI) – a computer-based transfer of data between the provider and payer through a data format for sending and receiving information.

Effective Date – the date the contract between the provider and insurance starts.

Electronic Funds Transfer (EFT) – the transfer of money from a third party payer into a physician’s bank account through a computerized system.

Electronic Health Records (EHR) – a computer based system for keeping patient records. (*Synonym: EMR*)

Employer Identification Number (EIN) – a tax ID assigned by the IRS.

Electronic Claim Filing – claims filed using a computer and billing software.

Electronic Remittance Advice (ERA) – an electronic form for claim adjustments and payment information.

Encounter Form – used to record charges that are generated during an office visit and detail the services provided. *(Also known as Superbill and the Chargemaster)*

Explanation of Benefits (EOB) – an explanation of what is covered as a billable service under the patient’s insurance policy or government health plan, including the fee for service, any adjustments, and the required amount the patient will be responsible for.

Exclusive Provider Organization (EPO) – an organization which provides benefits to individuals who pay premiums and receive healthcare services from providers considered network providers through a contracted managed care plan.

F

Facility – an organization or physical entity that provides medical care and services.

Facility Contract – a binding contract between two or more parties, which can be written for any medical provider.

Fee Schedule – a listing of fees for services that the insurance companies will reimburse.

Fee-for-Service (FFS) – a retrospective payment system that is used for billing services that were provided to the patient.

G

Group – participating physicians operating under an independent group providing healthcare services to individuals, usually used for credentialing or contracting purposes.

Group Contract – a binding contract between two or more parties who are operating under an independent healthcare service.

Group ID – a unique identification number to represent a specific group involved with a healthcare plan or organization.

Guarantor – the responsible party for paying any outstanding balances on the patient’s account (this may or may not be the same as the subscriber).

H

Hardship Policy – an established written policy by a healthcare facility that assists individuals who are unable to pay for necessary medical healthcare. *(See Donations)*

Healthcare Financing Administration (HCFA 1500) – a standard paper claim form, now called the CMS 1500.

Healthcare Procedure Coding System (HCPCS Codes) – codes that encompass Level I CPT and Level II National codes. Level II National codes have been developed by the Centers for Medicare and

Medicaid Services (CMS) to document procedures and services for third party payers for reimbursement. Level II codes are an alpha-numeric coding system that is used for submitting claims to identify products and supplies that are not covered in CPT codes. These include ambulatory services, durable medical equipment, prosthetics, orthotics, and supplies.

Healthcare Plan – a plan offered to individuals and groups for a monthly premium that provides healthcare coverage and accepts the risk of paying for any medical costs for medical treatment and services.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – a federal law that controls the privacy of health information nationwide and mandates the electronic transactions of healthcare information and assists with protecting health insurance coverage to individuals and their families when they change or lose their jobs.

Health Maintenance Organization (HMO) – an organization that provides comprehensive healthcare to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists; financed by fixed periodic payments determined in advance.

I

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9 Codes) – codes published by the World Health Organization (WHO) for documenting diagnoses and procedures and collecting data regarding diseases and injuries and used for medical billing.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10 Codes) – ICD-10 will replace the traditional ICD-9 coding system and will be implemented on October 1, 2014, to continue to report medical diagnoses and procedures to third party payers for reimbursement purposes but with more specificity.

In-Network – Physicians or healthcare facilities that participate and contract with third party payers to provide healthcare services; usually an in-network provider is reimbursed at a higher percentage than an out-of-network provider.

Incident to Physicians Services – services and supplies that are furnished as an incidental part of the healthcare provider's services to treat and diagnose an injury or illness.

Insurance Card – proof that that an individual has covered medical benefits through a commercial or government healthcare plan or program; contains information regarding submission of claims, payers name, insured name, member ID number, group name, co-payments and deductible information, plus benefit eligibility status. *(Also called Member ID card)*

Insurance Certificate – coverage (usually purchased by a healthcare facility or provider) issued by an insurance company that shows proof of medical malpractice liability coverage; lists individuals that are covered under the policy, the effective dates, expiration dates, type of insurance, and amount of coverage.

Insurance Validation, Verification – used to confirm the accuracy of the patient’s medical insurance to determine healthcare coverage.

Insured – participant(s) covered under a medical insurance policy either through a commercial or government policy or program.

J,K,L

M

Medicare Advantage Plan (MA) – an additionally purchased Medicare supplemental insurance that includes HMOs, PPOs, Fee-for-Service, Special Needs Plans, and Medicare Medical Savings Account Plans.

Managed Care Plans – healthcare delivery systems that integrate the financing and delivery of healthcare and generally negotiate agreements with providers to offer packaged healthcare benefits to covered individuals; includes Exclusive Provider Organizations (EPO), Integrated Delivery Systems (IDS), Health Maintenance Organizations (HMO), Point-of-Service (POS), and Preferred Provider Plans (PPO).

Mass Immunization – off-site immunization event usually provided for seasonal flu or pneumonia vaccinations for at-risk populations, seniors, or school-located vaccinations.

Medicaid – a jointly financed program by states and the federal government to assist with medical costs for individuals with lower incomes and limited resources.

Medical Director – a director of a medical facility who offers leadership, guidance, and quality assurance in a healthcare environment at an administrative level.

Medicare – a federally funded healthcare program for individuals 65 years of age or older, younger disabled individuals, and individuals with End-Stage Renal Disease

Medigap – refers to private insurance coverage that is purchased to fill any gaps not covered by original Medicare coverage.

Member ID – number given to medical insurance beneficiaries to use for identification purposes and to file claim.

Members – an individual who has coverage in a health insurance program, i.e., Blue Cross Blue Shield.

Modifiers – amendments to CPT or E/M codes that are used for more accurate reimbursement; they help explain additional circumstances to each procedure or service if the service has been modified or added to.

N

Network – group of individuals, such as doctors, hospitals, and healthcare facilities that operate under the same contracted healthcare plan.

Network Coinsurance – the percentage cost difference of in-network and out-of-network providers that is usually split between the subscriber and the plan share, i.e., the plan pays 80% and the member must pay the remaining 20%.

National Provider Identifier (NPI) – a 10-digit number authorized by HIPAA and assigned by the National Plan and Provider Enumeration System (NPPES) to identify healthcare providers for filing electronic claims with private and government insurance programs.

National Plan and Provider Enumeration System (NPPES) – developed by CMS to assign NPI numbers to identify providers to improve, secure, maintain, and update electronic delivery of health information while following HIPAA standards.

O

Off-site Clinic – a location separate to the main facility, i.e., at a public school, community center, or other off-site facility, relating to an immunization program for influenza or other vaccinations.

On-site Clinic – the primary location of a healthcare facility, such as the local health department or a Local Public Health Agency (LPHA), where immunizations and other outpatient services are offered.

Online Claim Filing – allows claims to be submitted for processing by a physician, hospital, or other healthcare facility to receive immediate confirmation that the claim has been received.

Out-of-Network Provider – a provider that is not contracted with an insurance company on negotiated rates for reimbursement.

Outpatient – any healthcare services that are provided without admitting the individual into a hospital setting.

Office Visit (OV) – a patient encounter with a healthcare provider in an office setting or an outpatient facility.

P

Physician's Assistant (PA, P.A.) – a mid-level medical practitioner who works under the supervision of a licensed doctor (MD) or osteopathic physician (DO).

Participating Provider (PAR) – a provider that is contracted with a third party payer and is considered an in-network provider.

Payer – a third party payer or insurance company that provides medical coverage to its members.

Pay to Address – the address that is provided by an agency or healthcare provider to an insurer to dictate where to send reimbursements.

Physician – an individual that practices medicine with the intent to diagnose and treat a condition or disease.

Practice Management software (PM) – software program for physicians and medical billers to manage varying aspects of a medical practice's day-to-day operations, including billing, clinical and quality improvement.

Place of Service (POS) – location where service was administered to the patient.

Point-of- Service Plan (POS Plan) – a plan in which the insured can choose to go outside the network or seek services directly from preferred providers.

Practice – a location where a medical professional or doctor practices medicine.

Practitioner – medical professional who practices medicine.

Pre-Existing Condition – a health problem that existed before the enrollment into a healthcare plan or program and can be denied by a health insurance plan; however, with the implementation of the Affordable Care Act anyone with a pre-existing condition will have the right to quality and affordable healthcare coverage and care regardless of their condition status.

Precertification – authorization for services given in advance by confirming eligibility and collecting data prior to the procedure being performed; requirements vary between third party payers.

Preferred Provider Organization (PPO) – a network of providers and healthcare facilities contracted with a third party payer on an in-network status; out-of-network providers may be accessed but at a higher fee to the member.

Premium – a fee that is paid into a health insurance plan by the policyholder or employer to cover health insurance.

Preventive Services – healthcare services which prolong life and prevent disease.

Primary Care Physician or Provider (PCP) – a physician that manages a patient's medical care.

Privacy Practices – privacy rule detailing the practices used by any medical provider or facility on protecting health information.

Private Fee-For-Services (PFFS) – a healthcare plan that pays providers on a fee-for-service for reimbursement on all or partial of medical costs that have been provided.

Procedure Codes – numeric codes that are classified in six sections; Evaluation and Management services, Anesthesia, Surgery, Radiology, Pathology and Laboratory services, and Medicine.

Protected Health Information (PHI) – The privacy rule following HIPAA standards of an individual's health information to identify an individual such as name, address, contact information, DOB, insurance policy ID number, social security number, employer, and any other medical record information relating to the patient's health must be protected.

Provider – a licensed healthcare professional who delivers services to patients in a practice

Provider Contract – a binding agreement between a provider and a third party payer to receive reimbursements on healthcare services delivered

Provider Enrollment, Chain and Ownership System (PECOS) – the PECOS system is an internet-based system developed by CMS as an alternate form for the Medicare CMS-855 enrollment application.

Provider Transaction Access Number (PTAN) – a number issued to providers by Medicare used to authenticate the provider

Q

R

Remittance Advice (RA) – information supplied by payers to providers showing explanation of payment, any adjustments made, denials, and uncovered charges of a medical claim.

Re-Credentialing – renewing and verifying credentialing information to maintain a contract between third party payers and providers.

Registration Form – documents demographic, health insurance coverage, and financial information of a patient before services are provided.

Retro (Retroactive) – a period of enactment where the third party payer permits the provider to bill for services before the arrival of the acceptance letter and prior to the effective date of healthcare coverage.

Roster Billing – used for Medicare enrolled providers for the billing process on mass immunizations that are provided to large groups for reimbursement.

S

Secondary Payer – a second health insurance policy that is used to pay on a claim after the primary health insurance is used to pay for health-related services.

Self-insured – an individual or businesses who take on the risk for themselves for their employees' medical costs with the purchase of a health insurance plan.

Specialist (SPEC) – a medical professional who specializes in a one area regarding to healthcare.

Start Date – the beginning date that allowable medical services can start to be reimbursed by a third party payer. *(Also known as Effective Date)*

Standing Order (SO) – a physician’s order that may be carried out by other healthcare professionals when certain conditions have been met

T

Tax Identification Number (TIN) – an identification number used by the Internal Revenue Service (IRS) for an employer or an individual provider to manage tax laws. *(Also known as the Employer Identification Number)*

Taxonomy Code – a code set which classifies the specialization of the healthcare provider or organization and is maintained by the National Uniform Claim Committee.

Third Party Payer – an organization that pays for medical services performed by a credentialed provider and processes claims for reimbursement covered by a healthcare plan or program.

Third Party Administrator (TPA) – an organization that administers medical claims for a separate entity.

Timely Filing – a period in which claims must be filed after the date of service was provided; requirements vary between third party payers.

Treatment Authorization – authorization for the provider(s) to administer treatment to a patient

Type of Service (TOS) – type of healthcare service provided to a patient; used to assign the proper codes for billing purposes.

TRICARE – a healthcare plan offering benefits to the uniformed military services, retired military members, and their families.

U

Usual, Customary, and Reasonable (UCR) – a method used for determining the allowed amount or fixed fee to be reimbursed based on the comparisons of what other providers are charging for similar services in the same geographic area.

United Healthcare (UHC) – a healthcare plan offered for a fee to employer groups, individuals, and families, to provide healthcare, dental, and pharmaceutical benefits to its beneficiaries.

Uninsured – an individual who is not covered by a medical insurance plan or program.

Under-Insured – an individual that is not covered under their healthcare plan or program for certain services or the plan or program only covers partial of the healthcare services provided to the patient.

Universal Credentialing Service (UCD) – developed by the CAQH for the credentialing process of providers and reduces any administrative issues

Unique Physician Identification Number (UPIN) – an alphanumeric code which contains information on providers and practitioners who are enrolled in the Medicare program; the UPIN number has been replaced by the National Provider Identifier. (*See NPI*)

V

Verification of Benefits – confirming the authenticity that an individual has the required healthcare coverage by contacting the third party payer on the member's benefits.

W

W-9 Form – a document issued by the United States Internal Revenue Service; needed when contracting with an insurer so they can document paid to information to the IRS.

Waiting Period – the amount of time before an employee or dependent is covered under the terms of the health plan or program.

X,Y,Z

3.2 Acronyms

A

ABN – Advanced Beneficiary Notice

ACIP – Advisory Committee on Immunization Practices

ACA – Affordable Care Act

AMA – American Medical Association

ANSI – American National Standard Institute

ARNP – Advanced Registered Nurse Practitioner

B

BCBS – Blue Cross Blue Shield

C

CAQH – Council for Affordable Quality Healthcare

CARC – Claim Adjustment Reason Code

CCHHS – Carson City Health and Human Services

CDC – Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CHN – Community Health Nurse(-ing)

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare and Medicaid Services

CPT – Current Procedural Terminology codes

CV – Curriculum Vitae

D

DHCFP – Division of Healthcare Financing and Policy

DHHS – Department of Health and Human Services (also HHS)

DOB – Date of Birth

DOS – Date of Service

DTaP – Diphtheria, Tetanus and Acellular Pertussis Vaccine

E

EDI – Electronic Data Interchange

EFT – Electronic Fund Transfers

EIN – Employer Identification Number

E/M Codes, E & M Codes – Evaluation and Management Codes

EMR – Electronic Medical Records

EOB – Explanation of Benefits

EPSDT – Early Periodic Screening & Development

ERA – Electronic Remittance Advice

ERISA – Employee Retirement Income Security Act

F

FDA – The Federal Food and Drug Administration

FFS – Fee-for-Service

FPL – Federal Poverty Level

FTE – Full-Time Employee

G

GEHA – Government Employees Health Association

H

HCFA – Healthcare Financing Administration

HCPCS – Healthcare Common Procedure Coding System

HHP – Hometown Health Plan

HHS – Health and Human Services

Hib – Haemophilus Influenza Type B Vaccine

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIT – Health Information Technology

HL7 – Health Level 7

HMO – Health Management Organization

HPN – Health Plan of Nevada

I

ICD-9 Codes – International Statistical Classification of Diseases and Related Health Problems, 9th version

ICD-10 – International Statistical Classification of Diseases and Related Health Problems, 10th version

IPV – Inactivated Polio Vaccine

IT – Information Technology

IUD – Intrauterine Device

IZ – Immunization

L

LHD – Local Health Department

M

MA – Medicare Advantage Plan

MBA – Masters of Business Administration

MCD – Medicaid

MCR – Medicare

MD – Medical Doctor

MMR – Measles Mumps and Rubella Vaccine

MMRV – Measles, Mumps, Rubella and Varicella Vaccine

N

NAC – Nevada Administrative Code

NACCHO – National Association of City and County Health Officials

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NDPBH – Nevada Division of Public and Behavioral Health (*formerly Nevada State Health Division*)

NP – Nurse Practitioner

NPI – National Provider Identifier

NPPE – National Plan and Provider Enumeration System

NRS – Nevada Revised Statutes

NSIP – Nevada State Immunization Program

NV PEBP – Nevada Public Employees' Benefits Program

O

OV – Office Visit

P

PA, P.A. – Physician's Assistant

PAR – Participating Provider

PCP – Primary Care Physician or Provider

PCV7 – Pneumococcal Vaccine

PDP – Prescription Drug Plan

PECOS – Provider Enrollment, Chain and Ownership System

PHI – Protected Health Information

PM – Practice Management Software

POS – Place of Service

POS Plan – Point-of-Service Plan

PPO – Preferred Provider Organization

PPS – Prospective Payment System

PTAN – Provider Transaction Access Number

R

RA – Remittance Advice

S

SNHD – Southern Nevada Health District

SO – Standing Order

SPEC – Specialist

T

TB – Tuberculosis

Tdap–Tetanus, Diphtheria and Pertussis vaccine

TIN – Tax Identification Number

TOS – Type of Service

TPA – Third Party Administrator

TPL – Third Party Liability

U

UHC – United Healthcare

UPD – Universal Provider Data Source

UPIN – Unique Physician Identification Number

V

VFC – Vaccines for Children

W

W-9 – Request for Taxpayer Identification Number and Certification form

WCHD – Washoe County Health District

WHO – World Health Organization

WIC – Women, Infants and Children

FORMS AND TEMPLATES

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4.1 Letter of Intent to Contract

[Your Name] **Insert a Letter head at the Top of the Letter as shown above**

[Street Address]

[City, St, Zip]

[Email Address- Optional]

[Today's Date]

[ATTN: Name of Recipient, if you have any]

[Title: Title of the recipient if you have any]

[Company: Network Contracting Department]

[Address]

[City, St, Zip]

[Dear (Name of the Recipient if you have any), if not use To Whom It May Concern:]

Please accept this letter as our interest in contracting with (carrier name) and your network partners. We are a Public Community Health Clinic providing the (area you serve) with immunizations, well-baby checks and Women's and Men's care.

The practice addresses are as follows:

[Name of Clinic: for example: ABC Clinic]

[Address for example: 123 Main St]

[City, St, Zip for example: Las Vegas, NV. 89000]

[Phone Number for example: 702-123-4567]

Tax ID# 00-1234567

Staff Providers:

John Doe, MD NPI: 987654321 (Collaborating Only)

Donald, Duck, APN NPI: 123456789

Minnie Mouse, APN NPI: 456321782

I look forward to hearing from you soon, so we can begin the contracting process.

Thank You,

Sincerely,

[Sign here for letters sent by mail or fax]

[Your Name and Department]

[Direct Phone Number]

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4.2 Superbill/Encounter Form

NEW PT VISIT		CLINIC TESTING		LAB TESTING	
99201	NEW PT - MINIMAL	82947	GLUCOSE	83655	ASSAY OF LEAD
99202	NEW PT - BRIEF	82270	HEMOCULT	85025	CBC WITH DIF
99203	NEW PT - LIMITED	86703	RAPID HIV	83655	LEAD
99204	NEW PT - INTERMEDIATE	85018	HGB/HCT	87491	CHLAMYDIA **** USE BOTH CODES
	ESTABLISHED PT VISIT	81025	PREGNANCY TEST (URINE)	87591	GONORRHEA**** USE BOTH CODES
99211	EST PT - MINIMAL	81003	URINE DIP	80053	COMP METABOLIC PANEL
99212	EST PT - BRIEF	87880	RAPID STREP	88142	PAP THIN PREP
99213	EST PT - LIMITED	36415	BLOOD DRAW	86709	HAAb, (M), IA
99214	EST PT - INTERMEDIATE	99000	SPECIMEN HANDLING FEE	87340	HEP B SURFACE Ag
	PREVENTITIVE NEW	88150	PAP SMEAR COLLECTION	86803	HEP C ANTIBODY
99381	NEW, INFANT	87210	WET MOUNT MICROSCOPIC	86694	HSV I AND II WITH REFLEX
99382	NEW, AGE 1-4		MEDICATIONS	86701	HIV-1 Ab, La
99383	NEW, AGE 5-11	ACT	ACTICIN	87255	HSV CULTURE AND TYPING
99384	NEW, 12-17	ACYC	ACYCLOVIR	80061	LIPID PANEL
99385	NEW, 18-39	BAC10	BACTRIM 800 /10 TABS	86592	RPR
	PREVENTITIVE ESTABLISHED	BAC20	BACTRIM 800 /20 TABS	84702	HCG, Quantitative
99391	EST, AGE 0-11mo	JO570	BICILLIN	87086	Cult, Qt Colony Cnt, Urine
99392	EST, AGE 1-4	CEPHA	CEPHALEXIN 500 40 TABS	84443	TSH
99393	EST, AGE 5-11	CIP10	CIPRO 500 10 TABS	86787	VARICELLA-ZOSTER ANTIBODY
99394	EST, 12-17	CIP20	CIPRO 500 20 TABS	36415	VENIPUNCTURE
99395	EST, 18-39	CLEO	CLEOCIN 2 %	83986	pH BODY FLUID
99396	EST, 40-64	CLIND	CLINDAMYCIN		CONTRACEPTION
	PROCEDURE CODES	CLOT	CLOTRIMAZOLE	54993	BIRTH CONTROL PILLS
58110	BX WITH COLPO	CONDY	CONDYLOX	J7307	IMPLANON
57454	BX CURETT OF CERVIX WITH SOPE	CYTO	CYTOTEC	J7302	IUD: MIRENA
17000	DESTROY BENIGN / PREMAL LESION	J8499	DOXYCYCLINE 100MG	J7300	IUC: COPPER 7
17003	ADDITIONAL LESIONS / DESTROY	ERTHY	ERYTHROMYCIN	A4266	DIAPHRAGM
54050	TX OF GENITAL WARTS MALE	FLAGY	FLAGYL 500 MG	A4268	CONTRACEPTIVE FILM
57061	TX OF GENITAL WARTS FEMALE	FLUCO	FLUCONAZOLE 150 MG	A4261	CONTRACEPTIVE CAP
57456	ECC WITH SCOPE	LOTRI	LOTRIMIN 1% CREAM	J7303	NUVA RING
57505	ECC	METRO	METROGEL	J7304	ORTHO EVRA PATCH (BOX 3)
57170	FITTING DIAPHRAM / INSTRUCTIONS	MICON	MICONAZOLE CREAM		IMMUNIZATION FEES
11981	INSERT DRUG IMPLANT DEVICE	MUC	MUPIROCIN	90471	IMMUNIZATION ADMIN 1 > 8 YEARS
58300	INSERT IUD	VITA	PRE NATAL VITAMINS	90472	IMMUNIZATION ADMIN 2+ > 8 YEARS
11982	REMOVE DRUG IMPLANT DEVICE	SUPRA	SUPRAX	90473	IMMUNIZATION ADMIN INTRANASAL/OR
58301	REMOVAL OF IUD	TER	TERCONAZOLE		INJECTABLES
		TRIAM	TRIAMCINOLONE 1% CREAM	J0696	ROCEPHIN 250MG (1 UNIT)
		EESZ!	ZITHROMAX	J1050	DEPO PROVERA
				96372	THER/PROPH/DIAG INJECTION SC/IM
	INFECTIOUS/PARASITIC DISEASES		G/GU		DERMATOLOGY
112.1	CANDIDAL VULVOVAGINITIS	455.6	HEMORRHOIDS, UNSPEC.	682.9	CELLULITIS, ABSCESS UNSPEC.
112.0	CANDIDIASIS OF MOUTH (THRUSH)	564.00	CONSTIPATION, UNSPEC.	684	IMPETIGO
483.1	CHLAMYDIA	590.80	PYELONEPHRITIS, UNSPEC.	691	DIAPER RASH
078.10	WARTS, VIRAL, UNSPEC.	599.0	UTI	692.9	DERMATITIS, UNSPEC.
079.99	VIRAL INFECTION, UNSPEC.	599.7	HEMATURIA	706.1	ACNE, OTHER
098.0	GONORRHEA, ACUTE (LOWER GU)	787.01	NAUSEA / VOMITING	708.9	URTICARIA/HIVES, UNSPEC.
054.9	HERPES SIMPLEX, W/O COMPLICA	787.91	DIARRHEA	774.6	JAUNDICE, NEONATAL UNSPEC.
V02.62	HEPATITIS C	788.1	DYSURIA	782.1	SKIN DISORDER NOS
078.0	MOLLUSCUM CONTAGIOSUM	789.0	ABDOMINAL PAIN		SUPPLEMENTAL CLASSIFICATION
133.0	SCABIES		FEMALE	V25.09	CONTRACEPTIVE MANAGEMENT
099.9	VENEREAL DISEASE, UNSPEC.	595.0	CYSTITIS, ACUTE	V70.0	GENERAL MEDICAL EXAM
131.0	TRICHONOMONIASIS	610.1	FIBROCYSTIC DISEASE	V72.3	GYNECOLOGIC EXAM W/PAP
110.9	TINEA	611.72	BREAST LUMP OR MASS	V20.2	WELL CHILD EXAM
132.9	LICE	614.9	PID	V25.1	INSERTION OF IUD
	NEOPLASMS	616.10	VAGINITIS/VULVITIS, UNSPEC.	V72.41	PREGNANCY TEST NEGATIVE
173.9	MALIGNANT SKIN, SITE UNSPEC.	626.8	MENSTRUAL DYSFUNCTION	V72.42	PREGNANCY TEST NEGATIVE
216.9	BENIGN SKIN, SITE UNSPEC.	627.2	MENOPAUSAL SYMPTOMS	V74.5	VENEREAL DISEASE SCREENING
	BLOOD DISEASES	759.02	PAP ANNUAL VISIT	V76.2	PAP ONLY
285.9	ANEMIA, UNSPEC.	V07.4	POSTMENOPAUSAL HRT	V74.1	TB SCREENING
	ENT		MALE	V01.6	EXPOSURE TO VENEREAL DISEASE
372.30	CONJUNCTIVITIS, NOS	302.72	IMPOTENCE	V76.19	CANCER SCREEN/BREAST
381.10	OTITIS EXTERNA, UNSPEC.	600.00	BPH	V25.09	FAMILY PLANNING ADVICE
382.00	OTITIS MEDIA	601.9	PROSTATITIS, NOS	V25.01	CONTRACEPTION, ORAL
PATIENT NAME «ptname»		ACCOUNT # «controlNo»		DATE OF BIRTH «dob»	
PROVIDER NAME				DATE OF SERVICE «encDate»	
				SIGNATURE	

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4.3 CMS 1500 Form

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

<input type="checkbox"/> PICA PICA <input type="checkbox"/>																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>					1a. INSURED'S ID. NUMBER (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name)					3. PATIENT'S BIRTH DATE SEX MM DD M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name)									
5. PATIENT'S ADDRESS (N CHY STATE					6. RESERVED FOR NUCC USE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (N CHY STATE									
ZIP CODE TELEPHONE (Include Area Code)					8. RESERVED FOR NUCC USE					ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name)					10. IS PATIENT'S CONDITION REFERRING?					11. INSURED'S POLICY GROUP OR FFC									
a. OTHER INSURED'S POLICY OR GROUP					a. EMPLOYMENT? (Current or former) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated)									
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM									
d. INSURANCE PLAN NAME OR PROGRAM					10d. CLAIM CODES (Designated)					d. IS THERE ANOTHER HEALTH REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a-</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information to process this claim. I also request payment of government benefits either to myself or to the patient. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information to process this claim. I also request payment of government benefits either to myself or to the patient. SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANT QUAL. MM DD YY					15. OTHER DATE QUAL. MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT CLAIM FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OT					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CLAIM FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Describe)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to ICD Inpt. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY to MM DD YY B. PLACE OF SERVICE C. EMG										D. PROCEDURES, SERVICES, OR (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNHS H. FFSH (Family Pay) I. ID. QUAL J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT (For only claims ssp) <input type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$										29. AMOUNT PAID \$					30. Reserved for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this form are true and correct.)										32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFORMATION ()				
SIGNED _____ DATE _____										a. NPI b. _____					a. NPI b. _____				

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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4.4 Medicare Roster Bill

Influenza/ Pneumococcal Pneumonia Virus Vaccine Roster

Provider Payee Name _____ Date of Service _____

Provider Number _____

	Insured's ID Number	Patient's Name (Last, First, MI)	Patient's Address (Number, Street, City, Zip Code)	Patient's Date of Birth	Sex	Patient's signature or "signature on file"
01						
02						
03						
04						
05						
06						
07						
08						
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11						
12						
13						

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4.5 Patient Statement

Patient Statement **1**

Business Name/ Logo
 Primary Business Address
 City, ST. Zip Code

Patient Statement

<input type="checkbox"/> Master Card <input type="checkbox"/> VISA <input type="checkbox"/> Check <input type="checkbox"/> Other	
Amount Due	Account Number
Exp. Date	Card Number
Payment Amount	Signature

RETURN SERVICE REQUESTED

Addressee

Patient Name
 Primary Business Address
 City, ST. Zip Code

Remit To:

Physicians Name/ Clinic Name
 Primary Business Address
 City, ST. Zip Code

Date of Service	Description of Service	Amount	Balance

Statement Date	Patient Name	Account Number	Amount Due

	Current	Over 30 Days	Over 60 Days	Over 90 Days	Total
Due from Patient					
Due from Insurance					

Please make check payable to Company Name/ Clinic Name

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RESOURCES

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5.1 Vaccine CPT and ICD-9 List

CPT CODE	ICD-9 CODE	VACCINE DESCRIPTION
90632	V05.3	Hepatitis A vaccine, adult Dose
90633	V05.3	Hepatitis A vaccine, pediatric/ adolescent dose
90636	V05.8	Hepatitis A and Hepatitis B, adult dose
90649	V04.89	Human Papilloma virus (HPV) vaccine, 3 dose schedule
90655	V04.81	Influenza virus vaccine, 6-35 months (Intramuscular)
90656	V04.81	Influenza virus vaccine, 3yrs and older (intramuscular) preservative free
90658	V04.81	Influenza virus vaccine, 3yrs and older (intramuscular)
90660	V04.81	Influenza virus vaccine (Intranasal)
90662	V04.81	Influenza virus vaccine, high dose (preservative free)
90670	V03.82	Pneumococcal vaccine, 13 valent (intramuscular)
90675	V04.5	Rabies vaccine (intramuscular)
90680	V04.89	Rotavirus Vaccine, 3 dose schedule (oral)
90700		DTaP vaccine <7yrs
90707	V06.9	MMR vaccine (subcutaneous)
90713	V04.0	Polio virus vaccine, IPV, (subcutaneous, intramuscular)
90714	V03.7	Td vaccine 7yrs > no preservatives (intramuscular)
90715	V06.1	Tdap vaccine 7yrs > (intramuscular)
90716	V05.4	Varicella virus vaccine (subcutaneous)
90723	V06.3	DTaP-HepB-IPV vaccine (intramuscular)
90732	V03.82	Pneumococcal vaccine (PPSV23)
90736	V04.89	Zoster (shingles) vaccine, (intramuscular)
90744	V05.3	Hep B vaccine, pediatric/ adolescent dose, 3 dose schedule (intramuscular)
90746	V05.3	Hep B vaccine, adult dose, 3 dose schedule (intramuscular)
90645	V03.81	HIB Vaccine

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5.2 ICD-9 Crosswalk to ICD-10

ICD-9	Description	ICD-10
011.90	PULMONARY TB NOS-UNSPEC	A15-A19
033.00	Pertussis	A37.01
052.90	Varicella	B01.0-B01.9, multiple
053.90	Herpes zoster without mention of complication	B02.9
053.90	Shingles	B02.9
054.90	Herpes simplex without mention of complication	B00.9
078.00	Molluscum contagiosum infection	B08.1
078.10	Condyloma	B07.9
079.99	viral infection in cce & uns site	B97.10, multiple
098.00	Gonorrhea	multiple
099.40	Urethritis, nonspecific	N34.1
099.49	NGU, other specified organism	N34.1
099.90	venereal disease NOS	A64
110.90	Tinea	B35.9
112.00	Candidiasis of mouth	B37.0, multiple
112.90	Yeast infection	B37.9
131.00	Urogenital Trichomoniasis NOS	A59.00
131.90	TRICHOMONIASIS NOS	A59.9
132.90	Lice	B85.2
133.00	Scabies	B86
173.80	Neoplasm, malignant, of skin of other specified sites	C44.80
173.90	Malignant Neoplasm skin site	C44.90
216.80	Nevus, pigmented, of skin of other specified sites	D22.9, multiple
216.90	Benign Neoplasm of skin site, NOS	D22.9, multiple
250.00	Diabetes mellitus type II	E11.9, multiple
250.01	IDDM	E10.9
250.02	Diabetes Mellitus Type 2, Uncontrolled	E11.65
250.82	Diabetes mellitus type 2 or unspecified type with other manifestations, unc	E11.69, multiple
250.93	Diabetes mellitus type 1 with unspecified manifestation, uncontrolled	E10.81, multiple
253.50	Diabetes insipidus NOS	E23.2
278.00	OBESITY NOS	E66.09, multiple
278.01	Morbid obesity	E66.01
280.90	Anemia due to iron deficiency	D50.9
285.90	Anemia NOS	D64.9
401.90	HTN [Hypertension]	I10
448.10	NEVUS, NON-NEOPLASTIC	I78.1
455.60	Hemorrhoids w/o mention complication	K64.0, multiple
483.10	Chlamydia	J16.0
550.90	Inguinal hernia, unilateral NOS without mention of obstruction or gangrene	K40.90
578.10	Hematochezia	K92.1
595.00	Acute cystitis	N30.00, multiple
597.80	Urethritis NOS	N34.1, multiple
599.00	UTI [Urinary tract infection]	N39.0
599.70	HEMATURIA NOS	R31.9

601.90	Prostatitis, NOS	N41.9
604.90	Epididymitis	N45.1, multiple
608.40	Boil of tunica vaginalis	N49.1, multiple
608.89	Testicular cyst	N44.1, multiple
649.10	OBESITY-UNSPECIFIED	O99.210
680.90	Boil of skin and subcutaneous tissue NOS	L02.92, multiple
682.90	Abscess of skin and subcutaneous tissue NOS	L02.91, multiple
704.80	Folliculitis	L66.3, multiple
706.10	Acne vulgaris	L70.0, multiple
709.90	Skin Lesion (unspecified)	L98.9
719.45	Pain, pelvis	M25.55, multiple
729.82	Cramp(s)	R25.2
780.79	Fatigue and Malaise	G93.3
782.10	Rash and other nonspecific skin eruption	R21
783.00	Anorexia	R63.0
783.10	Weight gain	R63.5
784.00	Headache	G44.1
788.10	Dysuria	R30.0, multiple
788.30	Incontinence	R32
788.41	Urinary Frequency/ Polyuria	R35.0
788.63	Urgency of urination	R39.15
789.00	Abdominal Pain (unspecified site)	R10.0, multiple
789.09	Abdominal pain, other specified site	R10.010, multiple
795.51	Nonspecific reaction to tuberculin skin test without active tuberculosis	R76.11
V01.1	TUBERCULOSIS CONTACT	Z20.1
V01.6	VENEREAL DIS CONTACT	Z20.2
V02.62	Hepatitis C Carrier	Z22.52
VACCINES DIAGNOSIS CODES CROSSWALK		
V03.81	Hib	Z23
V03.82	ND VAC STRPTCS PNEUMNI B	Z23
V03.89	ND OTHER SPECIF VACNATION	Z23
V03.89	Meningitis	Z23
V04.0	VACCIN FOR POLIOMYELITIS	Z23
V04.5	VACCIN FOR RABIES	Z23
V04.81	VACCIN FOR INFLUENZA	Z23
V04.89	HPV	Z23
V04.89	Rotavirus	Z23
V04.89	Zostavax	Z23
V05.3	Hepatitis A – peds	Z23
V05.4	NEED PRPHYL VC VARICELLA	Z23
V05.8	VACCIN FOR DISEASE NEC TWINRIX	Z23
V06.1	Tdap	Z23
V06.3	VACCIN FOR DTP + POLIO	Z23
V06.4	MMR	Z23
V06.5	VACCINATION FOR TD-DT	Z23
WELL VISITS CODES CROSSWALK		
V78.0	SCREEN-IRON DEFIC ANEMIA	Z13.0
V07.31	PROPHYLAC FLUORIDE ADMIN	Z41.8
V07.4	HORMONE REPLACE POSTMENO	Z79.890

V15.82	HISTORY OF TOBACCO USE	Z87.891
V70.5	HEALTH EXAM-GROUP SURVEY	Z02.1, multiple
V72.0	EYE & VISION EXAMINATION	Z01.00
V72.19	EXAM EARS & HEARING NEC	Z01.10, multiple
V20.2	ROUTIN CHILD HEALTH EXAM	Z00.121, multiple
V70.0	Exam, General Adult Medical	Z00.00, multiple
V21.1	PUBERTY	Z00.3
WOMEN'S HEALTH AND FAMILY PLANNING CODES CROSSWALK		
054.20	Herpes labialis	B00.2
112.10	Candidal vulvovaginitis	B37.3
597.89	Skene's gland adenitis	N34.2
611.60	Galactorrhea not associated with childbirth	N64.3
611.71	Mastalgia	N64.4
611.72	Lump in breast	N63
675.84	Breast and nipple infection NEC, postpartum	O91.23
256.40	Polycystic ovarian disease	E28.2
614.90	PID [Pelvic inflammatory disease]	N73.5, multiple
616.00	Cervicitis NOS	N72
616.10	Acute vaginitis	N76.0, multiple
616.11	Vaginitis and vulvovaginitis	A56.02
616.20	Bartholin's duct cyst	N75.0
617.90	Endometriosis	N80.9
618.00	VAGINAL WALL PROLPSE NOS	N81.9
620.20	Ovarian cyst NOS	N83.20
621.00	Endometrial polyp	N84.0, multiple
621.20	Enlarged uterus	N85.2
622.10	DYSPLASIA OF CERVIX NOS	N87.9
622.12	Moderate dysplasia of cervix	N87.1
623.50	leukorrhea	N89.8
625.00	Dyspareunia	N94.1
625.30	Dysmenorrhea	N94.4, multiple
625.40	Premenstrual dysphoric disorder	N94.3
625.90	FEM GENITAL SYMPTOMS NOS	N94.89
626.00	Amenorrhea	N91.0, multiple
626.10	Oligomenorrhea	N91.3, multiple
626.20	Menorrhagia	N92.0
626.40	Irregular bleeding NOS	N92.5
626.60	Bleeding unrelated to menstrual cycle	N92.1
626.70	Postcoital bleeding	N93.0
626.80	MENSTRUAL DISORDER NEC	N89.7, multiple
627.10	Postmenopausal bleeding	N95.0
627.20	Menopause, menopausal	N95.1
627.30	Atrophic Vaginitis	N95.2
633.90	Ectopic pregnancy	O00.9
634.91	Spontaneous abortion, incomplete, without mention of complication	O03.4
637.90	AB NOS UNCOMPLICAT-UNSP	Z33.2
640.00	Threatened abortion	O20.0
640.03	THREATEN ABORT-ANTEPART	O20.0
793.80	AB MAMMOGRAM NOS	R92.8

795.01	PAP smear of cervix (ASC-US)	R87.610
795.03	PAP SMEAR CERVIX W LGSIL	R87.612
795.04	PAP SMEAR CERVIX W HGSIL	R87.613
795.05	Cervical Human Papilloma Virus, DNA positive	R87.810
795.11	Vaginal Pap smear with atypical squamous cells of undetermined significance	R87.620
795.15	Vaginal high-risk human papillomavirus (HPV) DNA test positive	R87.811
V25.01	PRESCRIP-ORAL CONTRACEPT	Z30.011
V25.02	CONTRACEPTION INITIATION – OTHER	Z30.013, multiple
V25.03	EMERGENCY CONTRACEPTION MANAGEMENT	Z30.012
V25.09	OTHER FAMILY PLANNING ADVICE	Z30.09
V25.11	Insertion of IUC	Z30.430
V25.12	Removal of IUC	Z30.432
V25.13	Removal and Re-insertion of IUC	Z30.433
V25.40	CONTRACEPT SURVEILL NOS	Z30.40
V25.41	CONTRACEPT PILL SURVEILL	Z30.41
V25.42	IUD SURVEILLANCE	Z30.431
V25.43	Surveillance of subdermal Implantable contraception	Z30.49
V25.49	CONTRACEPT SURVEILL (OTHER) NEC	Z30.42, multiple
V25.5	INSERT IMPLANT SBDRM CNTRCEP	Z30.49
V25.8	CONTRACEPTIVE MANGMT NEC	Z30.8
V25.8	CONTRACEPTIVE MANGMT NEC	Z30.8
V25.9	UNSPECIFIED CONTRACEPTIVE MANGMT NOS	Z30.9
V26.49	PRECONCEPTION COUNSELING	Z31.69
V61.42	Substance abuse in family	Z63.79
V65.40	COUNSELING NOS	Z71.9
V65.44	HIV COUNSELING	Z71.7
V72.32	Encounter pap Cerv Smer Confirm nl Smer Flw Abn	Z01.42
V72.31	Exam, Gynecological	Z01.41, multiple
V72.32	CYTOLOGY SURVEILLANCE AFTER ASC_US OR LSIL	Z01.42
V72.32	CYTOLOGY SURVEILLANCE AFTER ASC_US OR LSIL	Z01.42
V72.41	PREGNANCY TEST NEGATIVE	Z32.02
V72.42	PREGNANCY TEST-POSITIVE	Z32.01
V73.88	CHLAMYDIA SCREENING	Z11.8
V73.89	Screen for Other Specified Viral Disease (Herpes, Hepatitis)	Z11.4, multiple
V73.99	SCRN UNSPCF VIRAL DIS	Z11.59
V74.1	SCREENING-PULMONARY TB	Z11.1
V74.5	SCREEN FOR VENERAL DIS	Z11.3
V76.2	SCREEN MAL NEOP-CERVIX	Z12.4
V76.19	Other Screening Breast Examination	Z12.39
V76.41	SCREEN MAL NEOP-RECTUM	Z12.12
V76.47	SCREEN MALIG NEOP-VAGINA	Z12.72
V77.1	SCREEN-DIABETES MELLITUS	Z13.1
V25.1	Enc for Insertion Intrauterine Contracept Device	Z30.430

5.4 Credentialing Checklist

- 1) Personal Information
- 2) Provider/Clinic NPI
- 3) Provider/Clinic Tax ID or EIN#
- 4) License Numbers and Copies of State license
- 5) DEA Numbers
- 6) Educational History
- 7) Board Certifications
- 8) Private Practice Details and Work History
- 9) Association Memberships
- 10) Proof of Liability Insurance
- 11) Peer References
- 12) Association Memberships
- 13) Completion of the Practitioner Questionnaire regarding malpractice or other disciplinary actions
- 14) Have provider or clinic director sign the signature lines. This depends on who you are contracting with and how they are contracting public health. Some carriers will contract directly with the APN, or PA and some will only contract with the clinic itself so be sure to ask when the credentialing process begins.

POLICIES AND PROCEDURES

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TABLE OF CONTENTS

6.1. Front Office

Sliding Fee Assessments

Title X Clients and Contributions

6.2 Billing Department

Scrubbing and Sending Claims

Overpayments and Refunds

Insufficient Checks Policy

Soft Collection Calls

Hardship Policy

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At the end of each visit all clients are shown an encounter form that indicates the total visit cost prior to any discount, the actual visit charge based on tier and the discounted difference between the two numbers.

- (f) All clients are then asked if they would like to contribute to the care they received.
 - i. Those in tier 5/below 100% of poverty will not receive a bill, as all services costs are discounted to zero.
 - ii. If the patient is tired at a 1-4 and unable to pay at the time of visit, the patient is not denied services.
- (g) Any remaining discounted fee is charged to this patient's account and collection is attempted at future visits.
- (h) Monthly statements are also mailed to patients in an attempt to collect past due balances.
- (i) The Clinical Services Division Manager may waive fees for clients.
- (j) In addition, the following clients will be considered in a Tier 5 category regardless of poverty level:
 - i. The patient is receiving Family Planning Services and is 17 years of age or younger.
 - ii. In a serious emergency, as determined by a clinician, no patient will be refused care due to an inability to pay.

Your Organization Name	Section:	
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Policy and Procedures Manual	Date:	
Title X Clients and Contributions	Supersedes:	

Purpose

A policy has been developed in order to address instances wherein the client may qualify for 100% reduction in charges based on their Federal Poverty Guidelines schedule under Title X however they would like to contribute money to the visit.

Policy

If a Title X patient has incurred charges for medical services provided but is deemed to be below 100% of the Federal poverty level based on household income (Tier 5), _____ will offer a 100% adjustment on the account which will reduce the balance to zero.

Procedure

To apply a donation/contribution:

1. At the time the patient is checking out, all clients are provided with a copy of their encounter form which indicates the total visit cost prior to any discount, the actual visit charge based on tier and the discounted difference between the two numbers.
2. All clients are then asked if they would like to contribute to the care they received. If the Tier 5 client makes a contribution the front desk receptionist posts the payment in the EMR as a contribution.

6.2 Billing Department

Your Organization Name	Section:	
	Page:	
Policy and Procedures Manual	Date:	
Scrubbing and Sending Claims	Supersedes:	

Purpose

A guideline for the procedure of scrubbing and sending claims has been created in order to ensure a timely and accurate filing process.

Policy

All claims will be viewed and check for accuracy within *(your organization's decision)* days of a patient visit. This will be done by the person responsible for doing the billing.

Procedure

On a basis the biller will examine each claim for the following:

- Is the patient's insurance information listed including name, address and payer id (if applicable)?
- Is the patient's insurance identification number listed?
- In the case of Nevada Medicaid, are their eleven digits to the ID number?
- Is the subscriber information listed along with date of birth and social security number if applicable?
- Is the patient and guarantor address listed?
- Are the CPT codes and ICD-9/10 codes linked?
- Are there any modifiers needed (apply as indicated)?
- Are there any co-pays applied and if so are they correct?
- Is the correct fee schedule (if applicable) chosen?
- Is the NDC number listed if applicable?

Your Organization Name	Section:	
	Page:	
Policy and Procedures Manual	Date:	
Overpayments and Refunds	Supersedes:	

Purpose

In order for the organization to maintain good standing with both client's and payers, a procedure has been created to determine an overpayment or refund due to either party.

Policy

As a monthly process, all claims will be reviewed for overpayments and refunds due and processed for payment to the appropriate party.

Procedure

As part of the Pre-Month End process a credit aging report is run in the EMR. This will create a list that can be copied and manipulated in an Excel spreadsheet which shows both patient and insurance carrier overpayments by claim number. This report is reviewed to determine the course of action needed to balance each account

If the credit in question is related to a Tier 5 self- pay patient please refer to the Contribution Policy and Procedure for directions on how to handle this situation.

If the credit stems from a patient overpayment, review the entire account to make sure there are no other outstanding balances that can be credited with those funds no matter the amount.

Additionally, if a pattern of recurring visits within a 3 month time frame is observed, leave the credit on account to be used at the next visit and make a note in the patient's chart "credit of ____ on acct."

_____ policy is to adjust any patient overpayment (or balance owing as well) of _____ or less if there are no other claims to apply this credit to and the patient comes infrequently.

Any amount that is due to the patient and cannot be processed in one of the ways detailed above, a refund request is created which includes detailed information resulting in the credit. This request is then routed to the clinic manager.

Refunds' requests for insurance carriers are generally the same except the back-up required is slightly different. You will need to print the EOB(s) to detail why a refund is needed.

These documented refund requests now go to finance where checks are cut and sent to the address you provided. You will receive copies of the actual checks and your back up which you will use to finalize the refund process. This information will be documented in the EMR.

Your Organization Name	Section:	
	Page:	
Policy and Procedures Manual	Date:	
Insufficient Check Funds	Supersedes:	

Purpose

A policy was created in order to address the instance of insufficient funds.

Policy

All clients will be treated equally and in compliance with the insufficient funds check policy unless waived by the clinic manager.

Procedure

If a client's check gets returned from the bank, the city finance department sends the returned check detail to the assigned CCHHS management assistant. This staff member documents the returned check charges by creating a certified letter notifying the client of the non-payment and requesting payment be taken care of as soon as possible. This Management Assistant then puts a copy in the biller's internal mail box and this prompts the biller to reverse the payment and add a NSF fee of \$25.00 to the client's account.

Tier 5 patients – If the returned check was a contribution, we will reverse the payment on account and the biller will document the issue in the claim log. The biller will call the patient or guarantor to ask them to bring in cash or money order to cover the original payment. If they are not able to comply with the request within 30 days the biller can adjust the account according to the Tier 5 policy.

All others –

If the payment is related to a specific visit we will reverse the payment on account and add a NSF fee of \$25.00. The assigned management assistant will process each returned check the same as above. If after 2 weeks no payment has been received, the biller will add a Billing Alert to the electronic health record. Clinical services staff will then attempt to collect the outstanding balance at the next appointment. If patient does not come back within a 6-month period, the account will be adjusted according to policy.

Your Organization Name	Section:	
	Page:	
Policy and Procedures Manual	Date:	
Soft Collection Calls	Supersedes:	

Purpose

A policy was created to give staff a process which to follow for calling patients with outstanding balances in an effort to recoup costs.

Policy

All patients with outstanding balances on their accounts will be treated fairly and with respect according to this policy. This process effective as of _____ will be used when time permits by the _____ in an effort to increase revenue by collecting patient balances that are over 90 days past due. We will not call anyone under 18 years of age or if their chart has been marked 'confidential – do not call'.

Procedure

- I. To gather the account balance information, either the biller or her assistant will run an AR report and import the report to an Excel spreadsheet to identify: **(this information will come from the EMR)**
 - A) Patient balance due
 - B) Highest Dollar amount
 - C) claim aging days

Be sure to choose accounts that are at least 90 days past due or have had 3 statements mailed to them.

- II. Make the call to the number on account. Ask to speak to the patient/guarantor and identify yourself and the clinic name. Tell them you are calling in regard to their account and ask them to confirm their identity by asking their date of birth or password. If they are unable to confirm this, do not go any further. Ask for a current number to call the patient directly. Thank them and check the chart for an alternative number. Only call home or cellular phones. Do not call work or emergency phone numbers for soft collections.
- III. Once identity has been confirmed, begin the conversation by letting them know that you are calling regarding the outstanding balance on their account and then ask if they have received the last few statements. If they say no, ask them to confirm their billing address, including any apartment numbers and make the necessary changes in the system. If the address we had was incorrect let the patient know that they will be receiving a statement in the mail OR offer to take their payment over the phone today to save a stamp. If your organization accepts Visa or MC and they choose this option obtain all required information to run the payment. If they do choose this method, offer to either email or U.S. mail the receipt if they would like it for their records.

Be sure to always let the patient/guarantor know that if they are unable to pay the balance due in full right now you can accept partial payments as often as they can pay toward the balance due.

- IV. Finally, at the end of the call be sure to note any payment arrangement information or the need to confirm address or phone numbers in the patient's chart. Also leave a note stating that you called the patient and left message to call back. That way the front desk can update the information in the next visit,

Leaving Messages

For privacy reasons, DO NOT Leave any messages that have any detail. Just leave your name, where you're calling from, number and message should say, "Please call me with regard to your account, Thank you". Then notate the date and time in the billing alert screen to keep a record of contact attempts.

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Policy and Procedures Manual	Date:	
Hardship Policy	Supersedes:	

Purpose

This Policy is intended to establish criteria to determine the appropriateness of waiving or lowering co-pays, co-insurance, and/or deductible amounts and to assure that any such waivers or reduced payments that may occur are authorized by this Policy. This policy also authorizes the Clinical Services Division Manager to lower or waive sliding fee balances in the event that a client is experiencing circumstances of financial hardship.

Policy

_____ will not waive or discount out-of-pocket amounts, and/or deductibles and/or coinsurance unless authorized by this Policy. The Clinical Services Divisions Manager may reduce or waive client sliding fee balances in the event of patient financial hardship.

Procedure

1. Waiver Policy.

It is the policy of _____ to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. However, if it is determined that the patient's financial situation meets the criteria in this policy and that a patient is financially unable to pay any out-of-pocket amounts, our Agency may waive or lower such amounts.

2. Other Policies

Under no circumstances will _____ engage in any of the following practices with respect to the waiver or lowering of co-insurance and/or deductibles:

- a. Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.
- b. Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for healthcare services provided by _____, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out-of-pocket expenses.
- c. *Routinely* use financial hardship forms which state that the patient is unable to pay co-insurance and deductible amounts
- d. Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence
- e. Accept "insurance only" or TWIP (take what insurance pays) as payment in full for services rendered.
- f. Fail to make a reasonable collection effort to collect a patient's balance.

3. Determination of Financial Need

- a. Decisions to waive or reduce any co-insurance, deductible and/or sliding fee amounts owed by a patient will be made on a **case-by-case** basis by the clinical services manager or her designee only.

4. Criteria considered for determining financial hardship

- a. Patient's or family's income in relationship to 100% of National Poverty level
 - 1) 100% waiver of all deductibles and co-pays if family income is equal to or less than 100% of National Poverty level.
- b. Circumstances that may lead to the reduction or lowering of co-insurance, deductibles and /or sliding scale fees may include but are not limited to, sudden death of primary income earner, recent unemployment of primary income earner, unexpected large expenses that make it difficult for a client to meet routine payments.
- c. Verification by Carson City Human Services Division that a patient is financially unable to make payments for food, housing or medical expenses.

JOB DESCRIPTIONS

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7.1 Job Description – Billing Specialist (Biller/Coder)

The Billing Specialist's primary responsibility is to compile and process the necessary information needed to submit an insurance claim either in electronic or paper claim format. This person should possess a good attention to detail and effective written and oral communication skills.

Key Responsibilities

- Comply with HIPAA standards and regulations
- Submit clean claims (after reviewed for correct coding) to private insurance and public carriers
- Follow up on outstanding claims
- Review rejected claims and submit appeals as indicated
- Work with a clearinghouse if needed
- Understand and follow established insurance industry policies and procedures
- Send statements to patients when applicable
- When time allows may be responsible for performing "soft" collections calls to patients with outstanding balances
- Create and review accounts receivable reports
- Create a daily deposit, and end of month report

Minimum Requirements

- High School diploma or equivalent
- Must be able to take responsibility and work under pressure
- Ability to work independently or collaboratively in a group
- Must possess good customer service skills
- Attention to detail and problem solving
- Ability to perform basic math problems
- Working knowledge of Microsoft Windows including Word and excel
- Ability to prioritize work and meet deadlines

Knowledge, Skills and Abilities:

- Working knowledge of insurance industry
- Be able to follow up on submitted or denied claims
- Basic knowledge of coding skills
- Certified in Medical claims and Billing preferred
- Ability to respond to patient's inquiries and complaints
- Knowledge in posting payments into patient's account and sending statements to patients if necessary
- Must be well organized and have strong communication skills
- Be able to act as a resource for patients, staff and insurance carriers

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7.2 Job Description – Receptionist

Welcomes and greets all patients and visitors, in person or over the phones

Key Responsibilities

- Answers the phone while maintaining a polite, consistent phone manner using proper telephone etiquette
- Responsible for keeping the reception area clean and organized
- Registers new patients and updates existing patient demographics by collecting patient detailed patient information including personal and financial information
- Facilitates patient flow by notifying the provider of patients' arrival, being aware of delays, and communicating with patients and clinical staff
- Responds to patients', prospective patients, and visitor inquiries in a courteous manner
- Keeps medical office supplies adequately stocked by anticipating inventory needs, placing orders, and monitoring office equipment
- Protects patient confidentiality by making sure protected health information is secured by not leaving PHI in plain sight and logging off the computer before leaving it unattended.

Minimum Requirements

- Education: High school diploma or graduation equivalency degree (GED).
- Knowledge of clinical procedures usually obtained from a certificate or Associates degree in a clinical program including anatomy, physiology, phlebotomy, first aid, and medical terminology.
- Knowledge of office procedures usually obtained from a certificate or Associates degree in a business program including administrative processes and procedures, claims processing, preparing patient charts, and basic computer skills.
- Experience: Entry level, previous office administration or receptionist experience or a minimum of one year work experience in a medical office setting.

Skills

- Telephone etiquette
- Customer service
- Basic word and excel programs
- Time management
- Multi-tasking
- Organization
- Scheduling