

# Elements for Successful Immunization Billing Practice

at New York State's Local Health Departments

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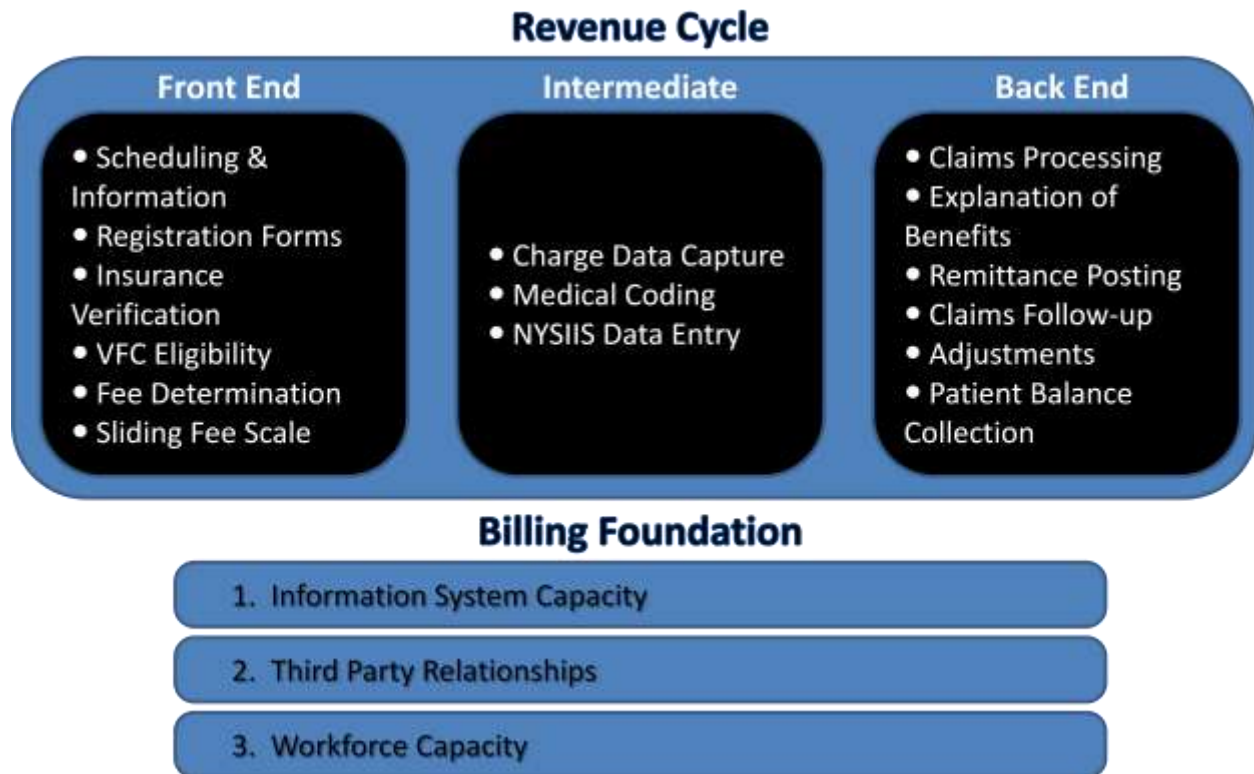
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## Introduction

This document is designed to systematically present the elements that must be addressed to enable effective revenue generating operations at local health departments (LHDs) providing immunizations. This information is intended primarily for immunization services, however much of it is applicable to billing for a range of services. The business requirements referred to are recommendations for effective practice. There is no single solution for many of the elements of the billing cycle, thus guidance and recommendations are given as opposed to a strict blueprint of a perfect billing system. The variability between LHDs ensures that there is no single approach that will work for all LHDs.

The document is organized to first review the processes involved in generating revenue for individual claims; the revenue cycle. The second section of the document details billing foundation elements that must be in place to support the revenue cycle processes. The business requirements must be considered in their entirety because so many factors are interrelated.

**Figure 1: Business processes for successful LHD immunization billing**



### **Revenue Cycle Management**

The **Revenue Cycle** is comprised of all financial processes associated with a patient visit, from registration to service, to billing, reimbursement and reporting. The processes can be categorized into three parts: Front-End processes, Intermediate processes and Back-End processes.

*Front-End processes* include scheduling, patient registration, Vaccines For Children (VFC) eligibility determination, insurance determination and verification, collection of co-pays, deductibles or self-pay amounts and sliding fee application. The information gathered at this stage of the process is critical to ensure that insurance claims are not denied for reasons such as invalid insurance coverage, service authorization not obtained or service not covered under the member's benefit plan.

*Intermediate processes* include the capture of service information in an electronic or manual encounter form. This includes procedure and diagnosis codes as well as other data elements required for billing third-party payers and New York State Immunization Information System (NYSIIS) data entry. Correct coding is important for submission of accurate reimbursement claims.

*Back-End processes* consist of electronic or manual submission of claims, posting payments to open accounts, claims follow-up and patient billing statements. In addition, back-end processes include those steps to account for paid and unpaid balances, write-off of unpaid balances and closure of each fee balance.

Providers need internal reporting tools and control mechanisms in place to ensure all claims are properly adjudicated and routine reports are created to monitor statistical and financial results.

The **Billing Foundation** of successful billing includes three components:

*Information System Capacity:* LHDs need an information system or service that can provide:

- Single-point patient data entry,

- Use by multiple clinical service areas within an LHD,
- Efficient NYSIIS data transmission,
- Electronic claim submission,
- Availability of service data for billing functions,
- Financial and statistical reporting capabilities, and
- Data import and export capabilities.

*Third party relationships:* LHDs need to develop relationships with insurance plans to obtain reimbursement for immunizations provided to enrolled patients, including:

- Network agreements with insurance plans,
- Credentialing of LHD practitioners with insurance plans so that LHDs can be reimbursed as network providers,
- Clearinghouse Agreements to enable streamlined LHD communication with payers. These services may be free or require contract agreements.

*Workforce Capacity and Capability:* LHDs need sufficient personnel resources to:

- Handle scheduling and registration,
- Submit claims, post payments and address outstanding accounts,
- Handle electronic claims, enrollment process and submit paperwork for electronic funds transfer (EFT) deposits from payers,
- Manage the health plan contracting and credentialing effort, and
- Handle information technology (IT) support for software implementation, maintenance and troubleshooting.

The following sections help describe the revenue cycle and the foundational aspects of billing in more detail.

# Revenue Cycle Management

## The Revenue Cycle

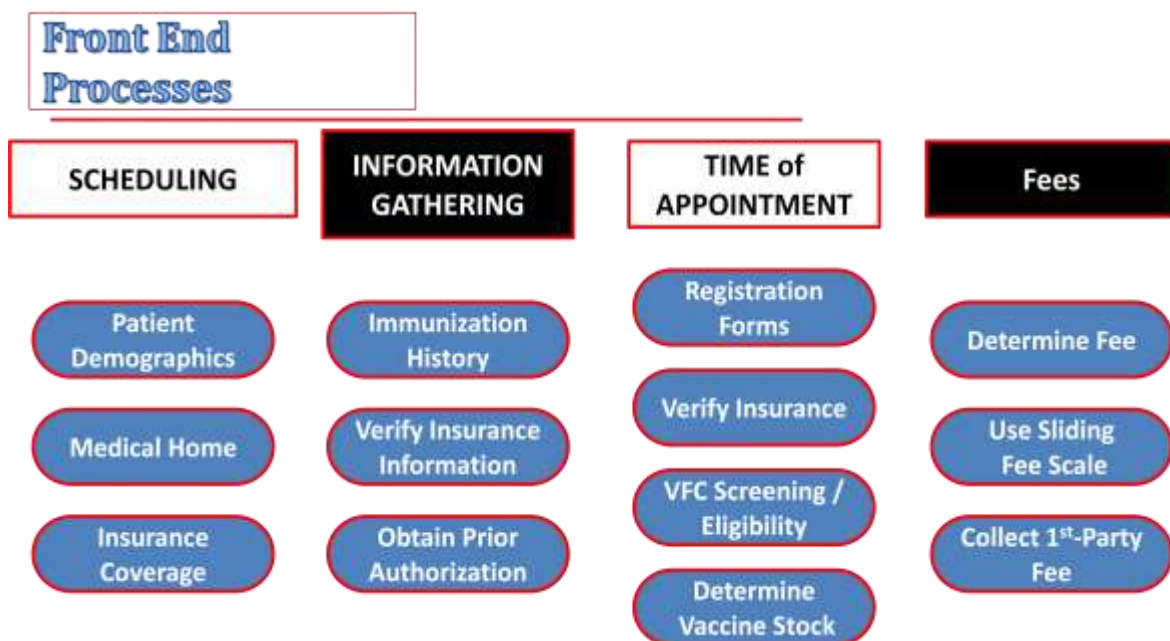
The revenue cycle is comprised of the paths that are taken from first contact with a patient through to resolution of the patient account. This is specific to each patient visit, allowing the LHD to standardize operations, collect all necessary information and efficiently obtain reimbursement as appropriate for each service delivered in immunization (or other) clinics.

### Front End Processes

Front-End processes are all of the steps that precede provision of services. Figure 2 shows these steps.

The Front End of the Revenue cycle can be broken down into scheduling, subsequent information gathering, actions that are required on the day of the appointment before services can be rendered and fees. When services are offered on a walk-in basis, the ability to collect necessary data is constrained and clinic staff do not have the time to gather and confirm data that they would otherwise have for scheduled services. The quality, accuracy and completeness of the information gathered during the front-end processing have a significant impact on the overall effectiveness and efficiency of the Revenue Cycle.

Figure 2: Front-End Processes



### Scheduling

Patients calling to schedule appointments at LHD immunization clinics are asked to provide information that enables the clinics to serve them in an efficient manner.

**1. Demographics:** When patients first contact LHDs for service, the LHD staff gather patient demographic information necessary to set up patient accounts and verify patient histories and insurance information.

**2. Medical Home:** LHDs inquire about usual sources of care and whether patients have tried to get timely service through this source before service is scheduled. This practice allows LHDs to assist patients in obtaining a usual source of care.

**3. Collect Insurance Information:** Also during the scheduling process, LHDs inquire about third-party insurance coverage, including Medicare, Medicaid or commercial plan information. Insurance information is important in determining potential eligibility for public programs. The insurance information is also required to determine whether patients are covered and whether they will need to pay for any portion of the fees out-of-pocket. Collection of third-party payer information during scheduling gives the LHD time to determine payer requirements. Third-party payers will generally fall into one of the following categories:

- Commercial;
- Medicare;
- Medicaid and Family Health Plus (FHP), or;
- Other Public (including Child Health Plus (CHP) and insurance associated with military service)

Changes to insurance information are entered into the LHD patient information system for each patient visit. LHDs collect third party payer information from all patients and document third party payers even for non-contracted payers. The following links provide general information about commercial managed care insurance plans and public insurance:

Managed Care:	<a href="http://www.health.ny.gov/health_care/managed_care/pdf/hmo_dir.pdf">http://www.health.ny.gov/health_care/managed_care/pdf/hmo_dir.pdf</a> <a href="http://www.health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf">http://www.health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf</a>
Medicare:	<a href="http://www.kff.org/medicare/7615.cfm">http://www.kff.org/medicare/7615.cfm</a>
Medicaid:	<a href="http://www.health.ny.gov/health_care/medicaid/program/">http://www.health.ny.gov/health_care/medicaid/program/</a>

Required insurance information includes

- Payer, e.g., Empire Blue Cross, NY Medicaid, Medicare B;
- Insurance Plan;
- Subscriber;
- Relationship of subscriber to patient; and
- Policy number and group number if applicable.

Check payer policies to ensure complete information documentation for each patient.

### **Information Gathering**

**Immunization History:** LHDs review patient immunization histories before services are provided to determine the immunizations needed. It is useful to access the New York State Immunization Information System (NYSIIS) before appointments for preliminary determination of required immunizations. It is necessary to request that certain patient groups whose records may not be in NYSIIS provide their immunization records in advance, or bring them at the time of appointment.

**Insurance Verification:** Whenever possible, LHD staff should perform an insurance verification check prior to delivery of services to determine if patient insurance coverage is active. The verification of insurance coverage can be performed manually by telephone, through payer websites or by using claims clearinghouses that have insurance verification capabilities. Some other entities, including vaccine manufacturers, also offer web-based insurance verification tools. Insurance verification can also be performed electronically in large batches through Health Insurance Portability and Accountability Act (HIPAA) compliant electronic data

interchange. Some Practice Management Information Systems (PMIS) communicate directly with claims clearinghouses, allowing providers to perform insurance verification through the PMIS interface.

Verification systems indicate whether the insurance is currently active, whether the service is covered, if annual or lifetime payment limits have been reached and if the patient has any payment responsibility. Eligibility verification will reduce claim rejections and denials by ensuring that the correct patient information is obtained and the patient is currently enrolled in their insurance plan. Insurance verification will also indicate the amount that patients have to pay in the form of deductibles, co-payments or co-insurance. It is important to:

- Confirm patient demographic and insurance information;
- Identify all medical benefit payers;
- Correctly identify the primary payer;
- Determine whether the services are a covered benefit;
- Determine patient out-of-pocket responsibilities, and;
- Determine insured patient co-payment co-insurance and deductible.

LHDs maintain contracts (See the Third Party Payer Relationships section of this document) to enable billing with select insurers. When patients seek LHD services outside of their insurance plan network, the LHD determines whether the insurance can be billed and how much will be paid. It may be necessary to call insurance plans with which the LHD does not have a contract to obtain this information.

**Prior Authorization:** Payers require providers to contact and request authorization for provision of many services as a prerequisite for claim payment. This generally means that an authorization code must be submitted as part of the service claim. Not obtaining required authorization leads to claim denial. Each insurer determines the services to which this applies and should be consulted for their specific policy.

### **Time of Appointment**

**Patient Registration:** Each patient goes through a registration process on the day of their appointment. This process includes documenting and verifying insurance information and completing paperwork authorizing LHDs to claim for insurance reimbursement on their behalf.

LHDs collect insurance information from patients, copy insurance cards and verify the insurance information on the day of the appointment before a patient is seen. A copy of the front and back of the insurance card should be made and maintained in the patient's record. Many health information systems have the capacity to associate an electronic copy of patient insurance cards with their records.

The patient or guardian must complete and sign documents in order for the LHD to submit service claims to payers. The forms include:

Assignment of Benefits (AOB) – this form authorizes the payer to pay the LHD directly. Without the patient/insured's signature the payer will send reimbursement to patients.

Authorization to Release Information – this form authorizes the LHD to release any patient and treatment information to the payer in order to claim reimbursement.

Advanced Beneficiary Notice (ABN) – this form is used only for Medicare when the LHD expects claims to be denied. Without the beneficiary's signature on the ABN, the LHD will be unable to bill the patient should a service be denied as non-covered by Medicare.

**Insurance Verification:** Thorough practices verify insurance on the day of service even if this was done previously. Insurance reimbursement will depend on continued coverage and patient



annual and lifetime maximums. Patient deductibles will also affect the patient out-of pocket payments. These details can change if patients change their insurance status or when providers submit insurance claims. Obtaining the most current coverage information through the verification process decreases the chances that coverage changes will affect back end operations.

**Vaccine for Children Eligibility Determination:** All patients less than 19 years of age must be screened for eligibility for the Vaccines for Children (VFC) program. Verification of VFC eligibility should occur each time the patient receives immunizations at the LHD. VFC participation requirements are detailed in the CDC VFC Operations Guide and on the NYS DOH VFC web page:

CDC VFC Operations Guide:	<a href="http://www.cdc.gov/vaccines/programs/vfc/providers/elig-scrn-rec-doc-req.htm">http://www.cdc.gov/vaccines/programs/vfc/providers/elig-scrn-rec-doc-req.htm</a>
NYS DOH VFC program website:	<a href="http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm">www.health.ny.gov/prevention/immunization/vaccines_for_children.htm</a>

**Public versus Private Stock:** It is important for the LHD to determine whether the patient will receive public stock vaccine, purchased by either the State or Federal governments, or private stock vaccine, purchased by the LHD. All VFC eligible children, including those enrolled in Child Health Plus, are to receive public stock vaccine. Public stock vaccines have specific eligibility criteria that must be satisfied. Private stock vaccine is purchased and provided for any immunizations offered to the population not eligible for public stock vaccine. LHDs must have policies and procedures in place to determine whether the patient is eligible for public or private stock vaccine, and for managing separate vaccine inventories. LHDs can use insurance information obtained and verified before patients arrive for services to make a preliminary VFC eligibility determination to trigger purchase of private stock vaccine. LHDs cannot charge for publicly funded vaccine.

### Fees

The General Public Health Work Program, defined by Article 6 of Public Health Law and Title 10 of the New York Code of Rules and Regulations (NYCRR) Sections 39 and 40 requires that each LHD establish a Fee and Revenue Plan. This plan includes fee schedules for services provided by the LHD. The fees are based on an actuarially sound assessment of the cost to provide services (New York Code of Rules and Regulations Title 10 NYCRR Section 40-1.64).

Immunization fee setting differs from many services due to the cost of the vaccine itself. Immunization fees are calculated as separate components: (1) *vaccine*, the cost of acquiring, storing and tracking the vaccine and (2) *administration*, staff time for scheduling, collecting insurance information, checking medical records, advising patients, administering the vaccine and entering data into NYSIIS. The following resources are geared to physicians and can be referred to for guidance in vaccine finance and billing practice:

NYS Association of Family Physicians Immunization Toolkit:	<a href="http://www.nysafp.org/images/uploads/misc/1288799439_NYSAFP-Immuniz-Toolkit.doc">www.nysafp.org/images/uploads/misc/1288799439_NYSAFP-Immuniz-Toolkit.doc</a>
American Association of Pediatrics (AAP) Vaccine Financing Toolkit:	<a href="http://www2.aap.org/immunization/pediatricians/financing.html">www2.aap.org/immunization/pediatricians/financing.html</a>
AAP Vaccine Survival Insert:	<a href="http://www2.aap.org/immunization/pediatricians/pdf/Vacc_survival_insert.pdf">www2.aap.org/immunization/pediatricians/pdf/Vacc_survival_insert.pdf</a>
Vaccine Fees:	<a href="http://practice.aap.org/public/The%20Bus%20Case%20for%20Pricing%20Vacc%20July10.pdf">http://practice.aap.org/public/The%20Bus%20Case%20for%20Pricing%20Vacc%20July10.pdf</a>
Administration Fees:	<a href="http://www2.aap.org/immunization/pediatricians/pdf/TheBusinessCase.pdf">www2.aap.org/immunization/pediatricians/pdf/TheBusinessCase.pdf</a>

Fees are established for each service. These fees apply to all services but the ultimate service

charge for each patient will depend on discounts that apply depending on the payer and the patients' ability to pay. Fee determination, discounting, sliding fee discounts and collection of service charges at the time of service are discussed in the following sections.

**Fee Determination:** The LHD must determine the service charge for each patient. Public health service charges are based on the service fee, insurance plan contracts and patients' ability to pay. LHDs cannot charge for vaccine obtained without acquisition cost from State or Federal governments. LHDs limit their charges as required for public insurers and adjust fees charged to third party payers according to allowable fee limits. Although fees are the same for all patients, not all patients pay the full fee.

**Sliding Fee Scale:** The sliding fee scale is a tool used to objectively discount fees based on patients' ability to pay. State Aid (10 NYCRR 40-1.63) regulations stipulate that sliding fee scales must be established and made available to all service recipients. This does not apply to amounts owed by insured individuals.

Each LHD must establish and apply a sliding fee scale and should do so based on the Health Resources and Services Administration (HRSA) guidelines and Federal Poverty Level schedule. According to HRSA, scales must have a low income cutoff below which out of pocket payments are discounted to 0 percent of the fee or a nominal charge and a high income cutoff above which all patients are charged the full fee. Between these cutoffs, there should be multiple income bands in which the patient out of pocket charge increases incrementally from full discount to full fee charged. The use of sliding fee scales is the primary means by which LHDs can remove financial barriers to care.

Sliding fee scale guidelines:	<a href="http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf">http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf</a>
Federal Poverty Level, 2012:	<a href="http://aspe.hhs.gov/poverty/12poverty.shtml">http://aspe.hhs.gov/poverty/12poverty.shtml</a>

**Collecting Out of Pocket Charges:** LHDs should collect service charges at the time of visit for self-pay patients. Insured individuals must often pay out of pocket to cover a portion of their allowable charge. Public and commercial insurers will determine what charges must be applied to their members and the VFC program sets a maximum administration fee that can be charged.

LHDs have established protocols for dealing with different insurance plans, determining whether full fees will be charged out of pocket or insurance claims will be submitted. Co-payment, co-insurance and deductibles must be paid out-of-pocket by many insured patients if claims are submitted. The out of pocket amounts can be found when insurance is verified and will depend on whether the provider has a contract with each payer. Contracting is discussed in the section on Third Party Relationships. Cost-sharing payments should be collected at the time of service.

The first dollar law (New York State Insurance Law sections 3216, 3221 and 4303) states that insured children less than 19 years of age do not have to pay any co-pays or deductibles for immunizations. The Affordable Care Act expands the number of health care plans that must cover immunizations without deductible or co-payment. However, not all plans are covered by these laws and the law does not apply for out of network services.

Medicare and Medicaid have strict rules on when patients are to be charged out of pocket. These rules must be followed. Medical providers are not allowed to ask for fees in association with clinical services.

The current VFC administration fee cap in New York is \$17.85. This can be charged out of pocket to VFC recipients without public insurance, subject to sliding fee scale application.

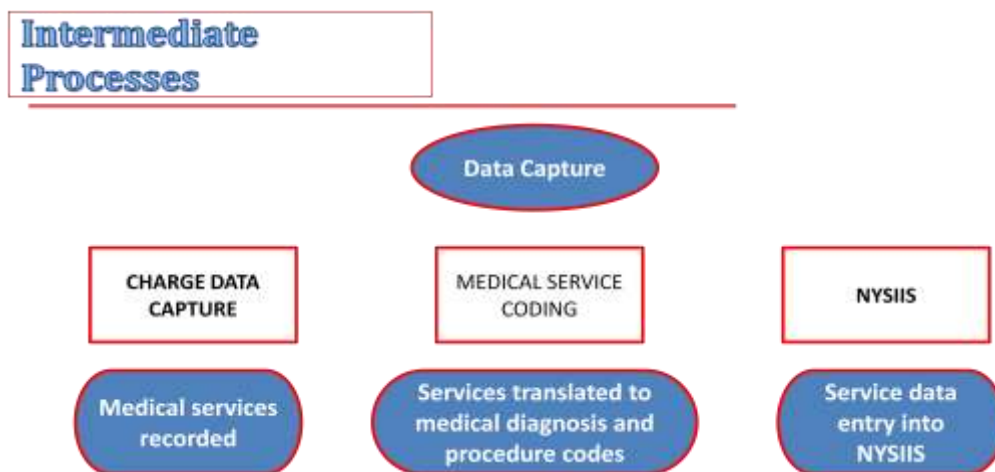
### **Waiving Fees**

LHDs may waive fees on an individual basis, as ordered by their director or commissioner. Waiving fees lacks the objectivity of the application of sliding fee scales.

## Intermediate Processes

The intermediate processes focus on the documentation of medical services, referred to as charge data capture, and appropriate medical service coding. Intermediate processes also include the entry of immunization information into the New York Immunization Information System, NYSIIS. It is best practice to complete these tasks during or shortly after the patient visit.

**Figure 3: Data collection in intermediate processes**



### Charge Data Capture

Charge data capture is the process of documenting the services rendered at the time of service. Establishing an accurate and complete encounter record for services provided is essential to timely and accurate billing.

For charge data capture, clinicians record information for each service provided, injection site and the method of administration. Each medical clinic has its own charge sheet designed to allow clinicians to efficiently record services. This typically includes a demographics section and a table of all standard services. Clinicians can fill out the charge sheet quickly by indicating which services were received. This sheet will serve as the source for data entered into the clinic information system and used for claim generation. Some practices have electronic systems for charge data capture.

### Coding Services

Coding is the process of translating recorded services into medical billing information. This translation can be done on a charge data sheet listing both services and medical codes or in a database designed to automatically match services with medical codes. Immunization coding consists of two parts; vaccine and administration as discussed above in the section on Setting Fees. Each immunization service is coded with a diagnosis code<sup>1</sup> (International Classification of Diseases, ICD-9) to designate the reason for the immunization, a procedure code ((Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS)) for the administration and a procedure code designating the vaccine used. The codes are updated yearly and standard coding guides are available for purchase. In some cases, modifier codes are required to further explain aspects of the service.

<sup>1</sup> The Department of Health and Human Services has proposed a one-year postponement of conversion from ICD-9 to ICD-10. The compliance date for this conversion before the announcement was made was October 1, 2013: <http://www.hhs.gov/news/press/2012pres/02/20120216a.html>

## NYSIIS

Each immunization provided to children less than 19 years of age must be entered into NYSIIS within two weeks of service. Entry can be done by manual entry or batch submission. LHDs request consent of adult patients (19 years and older) to allow entry of service data into NYSIIS. Prompt and complete entry of service data in NYSIIS is important for documentation of immunization records and can be completed as soon as services have been rendered. NYSIIS data entry can be done by clinical or administrative staff.

NYSIIS User Manual:	<a href="http://www.health.ny.gov/prevention/immunization/information_system/docs/user_manual.pdf">http://www.health.ny.gov/prevention/immunization/information_system/docs/user_manual.pdf</a>
Batch submission information:	<a href="http://www.health.ny.gov/prevention/immunization/information_system/providers/data_exchange_information/">www.health.ny.gov/prevention/immunization/information_system/providers/data_exchange_information/</a>

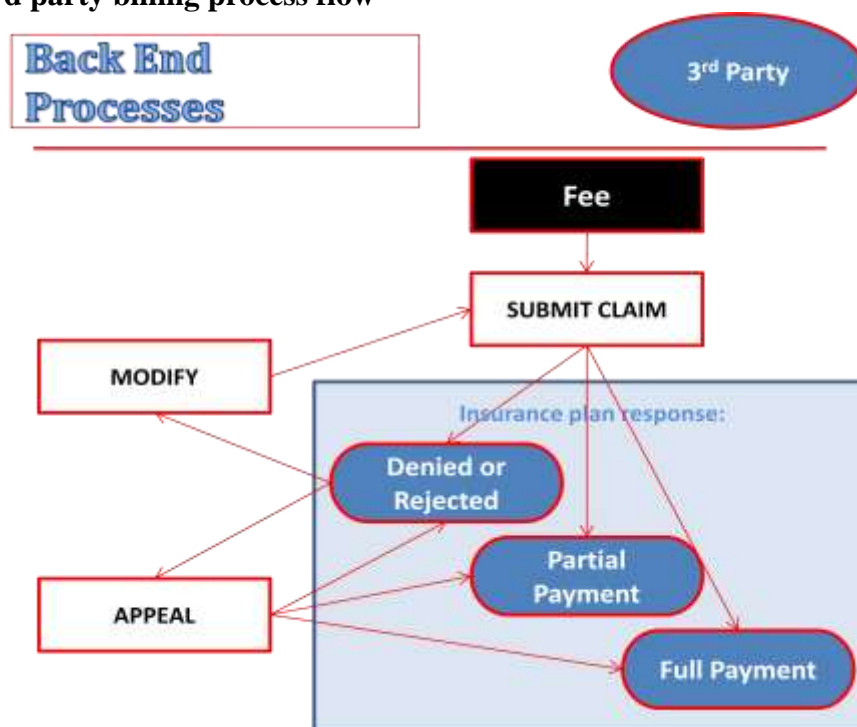
## Back End Processes

The revenue cycle Back End is the most complex area. Demographic data collection, insurance verification and service documentation collected in the front and intermediate processes prepare the LHD for the work that must be done in the Back End to pursue payment for services. It is possible to contract with external companies, referred to in this report as billing vendors, to perform some or all of the back end functions. These processes begin after the patient has left the clinic. Patients may have more than one insurance plan that must be billed appropriately. Back end processes are divided into third-party and first-party processes.

### Third Party Billing Processes

**Third-party** billing processes are those that involve both public and commercial insurers that pay for care on behalf of members. To summarize the process, it is initiated when providers submit fee and service information to the primary commercial or public insurance plan either on a paper claim or electronically. Insurance companies will reply to explain actions on the submitted claims. Claims denied by the insurance company should be corrected and resubmitted. If necessary, the LHD can submit an appeal through the insurer's established appeals process. The appeals process will result in payment or denial. The diagram below is an overview of the process which will be discussed in greater detail in the following paragraphs.

**Figure 4: Third party billing process flow**



Inside the box are insurance plan responses to claim submissions and appeals submitted by LHDs and other providers.

**Claims Submission:** Providers ensure that all of the necessary information has been gathered and enter it on the appropriate forms for paper or electronic claim submission. LHDs may be required to submit claims on professional or institutional claim forms.

Medical coding for immunization claims generally follows standard medical coding guidelines but many insurers use proprietary submission formats. Standard service coding is explained under Intermediate Processes. Some payers, notably New York State Fee-For-Service Medicaid, have non-standard claim coding requirements.

Electronic claim filing is more efficient than paper systems because they result in faster claim turnaround. As required by HIPAA, protected health information must be transmitted in a secure format.

This document discusses the forms that patients must complete to allow providers to claim reimbursement on their behalf in the Front End section on Patient Registration. Providers that use electronic claims must register for this service with insurers. LHDs may have greater success in submitting claims using a medical billing clearinghouse. The use of medical billing clearinghouses is discussed on the following page.

**Explanation of Benefits:** The claim response that insurance plans send to providers is known as the Explanation of Benefits (EOB). The EOB contains information vital to LHD's understanding of insurance claim response. EOB information may also be sent to the patient. Some of the EOB information includes:

- Service provided,
- Billed amount,
- Allowed amount,
- Excluded charges (denied or rejected),
- Explanation of excluded charges, and
- Patient responsibility (co-payment, co-insurance, deductible).

The EOB enables providers to adjust charges and outstanding balances for each patient and billed service.

**Remittance advices** are documents which summarize payments made by insurers to reimburse medical providers for services. Insurance plans send providers remittance advice slips that accompany payments received either electronically or via mailed paper checks. Remittance advices do not supply the claim level detail provided in the EOB. Each remittance contains payments for at least one claim, but often a single remittance includes payment for a number of claims. LHDs that use the same federal tax identification number as other county agencies may receive commingled remittances. LHDs must institute tools to track the receipt of funds.

**Cash application** is the process of posting payments against open balances. Each payment contained within a single remittance must be posted to the correct service balances. The amounts posted for the remittance must total the amount of the payment. Cash applications can be accounted either electronically via Electronic Remittance Advices (ERA) or manually with the assistance of the EOB on a claim by claim basis. ERA posting is the most efficient method to receive payments, as it saves time and increases accounting accuracy.

**Claims Follow-Up:** Effective management and follow-up for outstanding claims is critical to enhancing collection success. Management of denied claims can significantly improve the amount and turnaround time of revenue collected while minimizing the amount of bad debt write-offs and other adjustments. Electronic practice management systems frequently have the capacity to manage these functions.

In order to manage this process effectively the LHD should:

- Post all remittance data upon receipt;
- Use the EOB to determine claim rejection/denial issues;
- Take any necessary actions (resubmission, appeal, secondary insurance claim, patient statement) to resolve open or unpaid balances;
- As part of accounts receivable review, contact the insurer as necessary when no response is received for claims;

- Bill outstanding balances to secondary insurance or patients, and;
- Identify trends and take corrective action to reduce or eliminate avoidable claim denial.

**Remaining balances:** Insurers generally determine the amount that is reimbursed, known as the allowed amount. The allowed amount includes direct payments from the insurer to the provider and the patient responsibility in the form of deductibles, co-payments or co-insurance. The balance will need to be billed to the patient, as described in the next section, if it was not already collected at the time of service. If they have secondary insurance, the deductible, co-payment or co-insurance should be transferred to the patient’s secondary insurance and claimed as applicable.

### Medical Billing Clearinghouses

Claims processing is an integral part of the revenue cycle. Claims processing occurs between submission of claims and receipt of a response. This response represents the decision on claim acceptance and rejection, denial or payment of the claim with remittance advice. An efficient and effective claims process entails that all claims are submitted “clean”, with correct patient information and medical codes, in the correct format, and sent to the right payer in a timely manner. Medical billing clearinghouses help support submission of clean claims by acting as intermediaries for electronic claims submission and claims responses between providers and insurers. Other types of communication with insurers can be processed through payers or clearinghouses. An important example of this communication is eligibility verification.

The ability of providers to submit claims and associated communication electronically in HIPAA compliant formats and receive electronic remittance advices for payment posting is critical to an effective and efficient claiming operation. Claims clearinghouses provide this function. Clearinghouses offer some services free-of-charge; however, fees apply for other services. Services offered by clearinghouses may include; processing HIPAA compliant transactions, claims scrubbing and reporting. Claim scrubbing is an automated process for vetting claims employed by clearinghouses to ensure that all of the proper information is included. This is an initial process that enables immediate identification of claims that would not be accepted by payers, reducing claim rejection, speeding the process and allowing individual problem claims to be separated from batches of otherwise clean claims.

Clearinghouse contracts do not change the need for contracts between providers and payers. Providers using clearinghouses must notify insurers before submitting claims through a clearinghouse.

A provider can decide whether to use a clearinghouse or submit directly to the payer based on several factors:

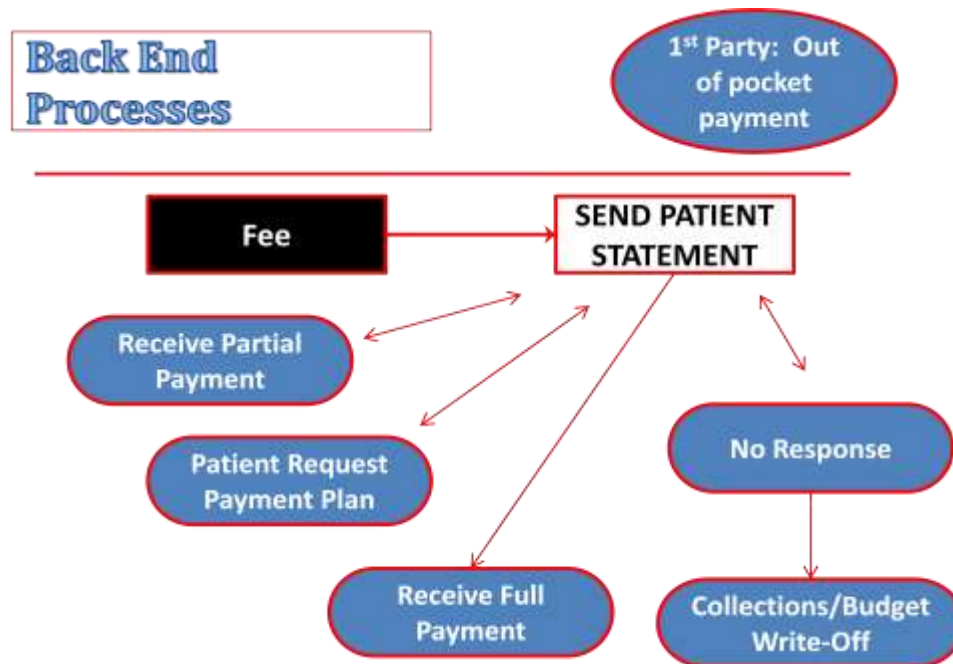
- Some payers work exclusively with claims clearinghouses and providers must submit claims through a clearinghouse.
- Some payers work with both clearinghouses and directly with providers so the provider can select either option.
- Some payers allow direct data entry of claims into the payers system for low volume providers.
- The provider has minimal IT support to build the proper data exchanges between the provider and payer, and it is more convenient and economical to work with a clearinghouse.
- Clearinghouses provide value added services in addition to just submitting claims. These services include: modules for resubmitting rejected claims online, claims scrubber software to validate CPT and diagnosis code usage and report generation.



## Collecting First Party Balances

**First-party** payment refers to payments made directly, out-of-pocket, by the patient to providers. First-party responsibilities should be determined and collected at the time of service whenever possible. This section refers to those out of pocket payments not collected at the time of service; these payments cost health departments more to pursue and are more difficult and time-consuming to collect. In the back end revenue processes, third-party reimbursement should be pursued and completed before first party payments are pursued. First-party billing is summarized in the diagram below.

**Figure 6: First party payment in the back end of the revenue cycle**



## Balance Billing

Most LHDs may choose not to balance bill in any case, however it would be a consideration if the allowed insurance amount is less than the cost of providing services.

Balance billing is the practice of healthcare providers billing patients out of pocket for fees in excess of allowed amounts determined by insurance plans. Allowable amounts include the charges the insurer pays and required patient out of pocket charges, i.e. co-payment, co-insurance or deductible. Non-participating providers may be allowed to bill patients for the difference between what the payer allows and their standard fee. In instances where balance billing is an option, it is to the discretion of the provider whether or not to attempt collection of the additional funds from the patient. Patients should be notified before receiving services when providers intend to balance bill.

The rules for when providers can balance bill is typically outlined in provider contracts. Most health insurance contracts forbid in-network providers from balance billing. This means that in-network providers must accept the payer's allowed amount for services rendered as payment in full.

Medicare and Medicaid have rules limiting out of pocket payments by members. Medicare allows non-participating providers to charge a defined percentage in excess of allowed amounts. Providers should notify patients in writing before providing services that may not be covered by Medicare. Medicaid providers are not allowed to charge unless the Medicaid plan has a required

out of pocket charge. Providers should determine the rules for each plan before attempting to charge insured patients out of pocket.

### ***Minimizing Outstanding Balances***

Patients will be billed out of pocket using mailed statements for outstanding balances after completion of third-party reimbursement processes. The need for this can be minimized by verifying insurance and collecting out of pocket payments at the time of service.

### ***Collections procedures***

Providers establish, document and enforce policies for billing patients. These policies determine how often and at what intervals statements will be mailed to patients to collect statement balances and what other methods will be used. The likelihood of collecting payment increases if LHDs establish payment plans when requested by patients. Collection procedures should be followed for payment plans as for other outstanding balances. Collection procedures determine the number of statements that are sent for unpaid balances and whether further action is taken, such as transfer to collections agencies.

### ***Financial Management***

Financial management processes enable LHDs to account for all of the expected and actual revenue and make a final resolution of outstanding balances. Ultimately, the revenue cycle for each service will be closed when payments are collected and any necessary adjustments are made. This resolution includes writing off bad debt for unpaid charges where necessary.

### ***Adjustments to Billed Claims***

LHDs make accounting adjustments when the total reimbursed is less than the standard fee. The possible reasons for the differences are:

- Sliding fee application or fee waiver (uninsured patients only)
- Co-payment or co-insurance
- Deductible
- Insurance payers discount provider fees based on usual and customary rates
- Contractual adjustment

Co-payment, co-insurance or deductibles must be collected from patients. Contractual adjustments represent the difference between customary fees and negotiated reimbursement rates. LHDs will have to adjust the balance. Ultimately, each encounter charge should be closed and the outstanding balance should equal zero, once all activity is processed, including adjustments and write-offs. Below is a sample transaction:

**Figure 6: Sample activity for services covered by insurance with co-payment due**

		<b>Amount</b>	<b>Comment</b>
Gross fee		\$125.00	Standard service fee
Sliding scale fee		N/A	Insured patient
Waiver		N/A	Insured patient
<b>Third party reimbursement</b>			
Primary insurance	Allowed amount	\$100.00	
	Patient responsibility	\$25.00	Co-payment, co-insurance or deductible
	Contractual	\$25.00	Fee minus allowed
	Paid amount	\$75.00	Amount reimbursed and collected from Payer
Secondary insurance	Amount remaining	N/A	If primary paid, generally patient responsibility from above
	Patient responsibility	N/A	
	Paid amount	N/A	Amount reimbursed and collected from Payer
<b>First party reimbursement</b>			
	Charge	\$25.00	equal to patient responsibility for insured patients, or total charge for uninsured
	Paid amount	\$25.00	1st party payment
<b>Billing summary</b>			
Total third party payment		\$75.00	
Total first party payment		\$25.00	
Total reimbursement		\$100.00	Amount collected from payer and patient
Total adjustment		\$25.00	Standard fee minus amount charged
Total write-off			Amount charged minus reimbursement (i.e. uncollected amount)
Account balance		<u>\$0.00</u>	

**Bad Debt Write-Off:** Providers should have procedures for writing off amounts that cannot be collected after exhausting third party reimbursement and first party collections procedures. These policies will determine what collection attempts must be made and what additional approval is needed before balances can be written-off as bad debt. The value of and reason for bad-debt write-offs should be documented and tracked.

**Financial tracking:** Optimally each practice has a comprehensive claim review system to ensure that all services have a clear fiscal trail. Many services at LHDs do not result in insurance claims, particularly for the uninsured, when payment is collected directly from the patient and for some services no charge will be applied due to sliding fee scale application. The fiscal tracking and accounting system should be designed to show fees, sliding fee discounts, patient payments, insurance payments, adjustments and balance. Claiming operations are aided by a function to allow tracking of claim by date of service to help prioritize and ensure timely settlement of claims. All services should end the Revenue Cycle with an outstanding balance of \$0.

### **Outsourcing**

Some LHDs choose to contract with external companies to provide third party billing services. Such medical billing companies receive service data from providers and use this data to complete the functions of the revenue cycle back end. LHDs may choose to outsource third party billing and may also choose to contract out back end first party billing. Some LHDs find this an efficient way of obtaining specialized services to increase billing efficiency and effectiveness. Such LHDs determine contract specifics including the collections process to ensure that reimbursement is pursued in a manner that meets public health objectives.

# Third party billing foundation

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## Billing Foundation

This portion of the document discusses major components underlying a successful LHD revenue operation. These elements provide the foundation essential for smooth revenue cycle function: information system capacity, third party payer relationships and workforce capacity.

## Information System Capacity

### Health Information Systems Requirements

Health Information Systems are designed to collect, store and exchange patient data throughout medical provider practices. Health information systems include data on business and clinical functions and can be used to share health care data in a secure manner with other entities, such as third-party payers and provider offices. The LHD's individual needs and priorities will largely determine the size and scope of its use of a health information system. This document covers two types of information systems: Practice Management Information Systems (PMIS) and Electronic Health Records (EHR).

**Core Functions of a Health Information System:** LHDs have data needs that are both unique and similar to needs of other providers. Because of unique service and reporting requirements, LHDs frequently use multiple information systems. Selection and coordination of information systems is crucial. LHDs will find it beneficial to map programs served, information system needs, nature of databases (e.g. web-based, local network, key data requirements, means of acquiring data and data sources, local spreadsheet) and maintenance status. This may help to eliminate redundant information systems without losing functionality.

An information system for LHD immunization billing should be able to:

- Collect patient data and prevent duplicate data entry
- Use demographic, service and payer information for billing operations
- Function for variety of clinical services
- Handle NYSIIS batch submission
- Generate claims electronically
- Handle accounting of claim payments
- Generate financial and statistical reports
- Import/export data from other systems.

### Practice Management Information Systems (PMIS)

Practice Management Information Systems help to organize all business and some clinical information. The PMIS helps providers manage scheduling, registration, insurance verification, encounter documentation, billing, and collections. Integration between all major clinic information systems and the ability to import and export data are important features of a PMIS. For instance, LHDs that contract out back end functions need functionality to enable transmission of billing data to their billing vendor to eliminate duplicate service data entry.

### Electronic Health Record (EHR)

The primary feature of an EHR is the documentation and storage of patient medical data in an electronic format, eliminating the need for paper systems. The EHR consolidates medical information on each patient allowing greater ease in record navigation. A benefit of using an EHR system within New York State is the potential to electronically transfer vaccination data to

NYSIIS, eliminating the need for manual data entry of vaccinations and increasing the efficiency and accuracy of data transfer.

Electronic Health Records differ from PMIS in that some only record the results of medical examinations and procedures in an organized fashion for use in medical care, whereas the PMIS can record practice specific aspects of what procedures are performed and the financial aspects of care. However, many EHR systems include a practice management module, such that scheduling, patient registration, insurance data, health history, medications, immunization history, claiming and accounts receivable management are integrated into one system.

**Electronic Health Record Incentive Program:** A recently enacted governmental program provides financial incentives for medical practices to upgrade to an EHR system. Funding is provided under the Health Information Technology for Economic and Clinical Health (HITECH) program. To receive federal incentives, providers must select a new EHR system or validate an existing EHR system against the Department of Health and Human Services' (HHS) certification requirements.

In order for a provider to qualify for the HITECH incentives, HHS has included both complete EHR systems and EHR modules in its definition of certified technology. This means that providers can:

- Purchase a comprehensive certified package from a single vendor or
- Purchase certified components from different vendors.

In order to receive incentive payments, providers must also meet specified meaningful use objectives.

EHR meaningful use incentive program	<a href="https://www.cms.gov/EHRIncentivePrograms/">https://www.cms.gov/EHRIncentivePrograms/</a>
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### Reporting Capabilities

Information systems provide the ability to produce reports for billing operations and management workflow monitoring and quality control. The primary value of reports is internal. LHDs with adequate reporting functions are able to effectively manage clinic and billing practice based upon knowledge rather than supposition. This knowledge helps to streamline processes, identify and correct weaknesses and to pinpoint priority areas.

Reports detailing aspects of clinical and billing practice are critical to the long term viability of any business entity, including government entities. Reports can be used to demonstrate whether the population in need is being adequately served and whether the funding is being appropriately spent.

## Third Party Payer Relationships

Third party payer relationships include contractual agreements with insurance plans and the credentialing that is necessary to document authority to provide medical services. Insurance plans require providers to complete the credentialing process before paying insurance claims.

### Contracting with Third Party Payers

Provider contracts are agreements between medical providers who provide care and healthcare insurers. These contracts detail services to be provided, payment rates and other obligations of each party. The medical provider benefits from contracts because this relationship results in reliable reimbursement rates and encourages insurance plan members to seek care at the contracted provider, increasing business volume. Managed care insurers benefit from establishing a network of medical providers to provide sufficient accessible medical care resources for their members and because contracts set favorable service payment rates.

Out-of-network providers are professionals or organizations who have no provider contract with a payer. Insurers may pay for out of network services at a lower reimbursement rate, or not at all. Coverage rates depend on the benefit structure that members agree to when they enroll in the insurance plan. A patient who uses an out-of-network provider may be required to pay deductible and/or co-pay amounts that are greater than those at network providers.

This section will discuss the major types of insurers and how they use provider contracting. This section will also list some of the major insurance plans active in New York State, regulations governing insurance contracting, the process for obtaining contracts and additional considerations in selecting insurance plans for contracting. This section will finally discuss enrollment in public insurance programs Medicare and Medicaid.

**Payer Types:** There are several different kinds of health insurance payers. Major payer types are:

- Health Maintenance Organization (HMO) – Members may only use those providers who have a contract with an HMO.
- Point of Service (POS) – Members may use providers outside of the payer network, however, differential deductible and/or co-insurance are applied. Members may use out of network providers at no extra cost if referred by an in-network provider.
- Preferred Provider Organization (PPO) – Members may use providers outside the payer network; however, differential deductible and/or co-insurance are applied.
- Indemnity – Members have the right to use any provider without differential reimbursement.

The value of a particular contract between a health insurance payer and a LHD can be assessed based upon the volume of patients who have a particular insurance plan in the LHD service area, contract reimbursement rates, patient enrollment and any benefits in regards to claim adjudication or payment turnaround time which a contract may provide. Some LHDs will find payer communication and claim turnaround will improve when they have a contract. Payer type as indicated above will determine the terms of in- and out-of-network provider reimbursement.

**Major Payers in New York State:** Some of the major insurance plans that operate within New York State are:

- Medicare
- Medicaid
- Aetna
- BCBS of Western New York
- BCBS Northeastern New York

- Capital District Physicians’ Health Plan
- Empire Blue Cross
- Excellus BCBS
- Fidelis Care (New York State Catholic Health Plan)
- Health Insurance Plan of New York (HIP)
- Independent Health Insurance
- MVP Health Care
- United Health Care

Plans generally offer multiple benefit packages that vary by services covered.

**Contracting regulations:** Regulations and contractual obligations affect how insurers do business, particularly the federal Affordable Care Act of 2010 (ACA), the State’s First Dollar Coverage Law and the federal Employee Retirement Income Security Act (ERISA). Patients who use providers who are in-network with their insurer will not be assessed deductible or co-pay amounts for immunization services that are considered preventative care for plans subject to the 2010 Affordable Care Act. Some insurance plans continue to be exempt from this and other 2010 Affordable Care Act provisions.

New York State Insurance Department website; information on provider rights	<a href="http://www.dfs.ny.gov/insurance/hprovrgh.t.htm">http://www.dfs.ny.gov/insurance/hprovrgh.t.htm</a>
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Managed care insurance plans are required by New York State to establish networks with sufficient providers; however, insurance plans may refuse to contract with individual providers. There is no legal requirement that commercial health insurance plans reimburse medical providers who are outside of their network for services provided to their members.

**Contracting Process:** Information gathered during the revenue cycle at the front end can be used to compile a payer mix profile reflecting insurance plans and the services provided. This payer mix information can then be used to prioritize and focus contracting efforts on payers with the highest number of members with the provider. LHDs can perform the following steps to determine the payer mix:

1. At each patient visit, record insurance information for each patient,
2. At the end of a given time period (one or more months), compile a report summarizing the number of patient visits by payer,
3. Calculate the payer mix percentage based on the number of patient visits, and,
4. Gross charges can also be used in place of patient visits to calculate an estimated financial share of each potential payment source.

Although the contracting process is straightforward, it does require time and effort to complete contracts. The typical process can take three to four months depending upon how quickly the LHD can review and agree to the language in the payer’s contract. Basic steps to contracting are:

1. Contact the Payer’s Contracting Department;
2. Identify the provider representative that handles your coverage area;
3. Explain to the provider representative the type of agreement the LHD wishes to establish with the payer;
  - a. In-Network Specialty Provider
    - Not in Provider Network Directory option
  - b. In-Network Primary Care Provider (PCP)
4. Discuss the type of services that will be covered under the contract;
5. Discuss the fee schedule that will be used to determine the reimbursement rates;

6. Have the Legal department review the contract agreement;
7. Sign contract once it has been approved by the payer and the health care provider's Legal staff.

There is some room for negotiation with payers, but it is usually limited for small providers such as public health agencies. Large hospitals and physician networks have leverage to negotiate reimbursement rates and types of services covered under the contract. Contracts frequently cover defined groups of services. LHDs should ensure that contracts cover the range of services provided within their organization.

Most contracts are open ended and do not have a termination date. However, either party can terminate the contract agreement usually with 60 – 90 days notice. Additionally, reimbursement rates are adjusted by the payer and will apply to all providers under the standard contract agreement. Contract agreements delineate the responsibilities of both the provider and the payer to have a claim processed and paid timely and correctly. The contract should include:

- A description of the reimbursement methodology to be used under the agreement;
- Language which addresses the prompt payment for claims;
- The dispute resolution process for resolving provider appeals;
- Language which requires the payer to notify the provider in writing at least 30 days prior to any changes to the agreement, policies or procedures; and
- A contract provision which states that neither the provider nor payer can terminate the agreement without cause with less than 60 days written prior notice.

The LHD should routinely review payments received to verify that the claims are being processed and paid at the correct contract rate and that all provisions of the contract are being met.

**Other Contract Considerations:** Contract negotiations are generally confidential and parties cannot discuss financial details with other parties, particularly other insurers and medical providers. Contracts are likely to address member out of pocket payments including co-payments, co-insurance, deductibles and balance billing. Provider contracts will specify services that the LHD is contracted to provide and indicate whether there are limitations on the population to which the contract pertains, within the membership of the contracted plan.

**Public insurance programs:** Publicly insured patients represent the largest segment of patients served at LHDs. LHDs generally are enrolled providers in public third party health insurance programs. These programs have strict rules about requesting patient out of pocket payment. This section gives a brief review of the process for Medicaid and Medicare provider enrollment and discusses managed care in public health insurance programs. Medicare and Medicaid enrolled providers can bill traditional fee for service enrollees, however many public insurance beneficiaries have managed care plans that may have network restrictions.

*Medicaid Provider Enrollment:* Providers must apply through the eMedNY system to participate in Medicaid. Approved applicants are notified of their provider ID number and the effective date when the provider may begin serving enrolled beneficiaries. Required documentation to be submitted to Medicaid includes:

- Medicaid Provider Enrollment: Group Enrollment Form
- Disclosure of Ownership and Control
- Federal Employer Identification Number
- Medicaid Provider Enrollment: Group Member List
- Office of Medicaid Inspector General provider compliance confirmation



- Request for Participation as a Group Member

More information regarding Medicaid enrollment can be found at:

Medicaid application index	<a href="https://www.emedny.org/info/ProviderEnrollment/index.aspx">https://www.emedny.org/info/ProviderEnrollment/index.aspx</a>
Application specific to LHDs	<a href="https://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4260-Group%20Enrollment%20Packet/4260-Group.pdf">https://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4260-Group%20Enrollment%20Packet/4260-Group.pdf</a>

*Medicare Provider Enrollment:* Providers must enroll in the Medicare Program to receive reimbursement for services furnished to Medicare beneficiaries or to order covered items or services for Medicare beneficiaries.

Medicare application	<a href="http://www.cms.gov/CMSforms/downloads/cms855b.pdf">http://www.cms.gov/CMSforms/downloads/cms855b.pdf</a>
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*Managed care in public health insurance programs:* Approximately 80 percent of Medicaid beneficiaries are enrolled in managed care plans. Child Health Plus (CHP) is another publicly funded insurance program and all members of CHP are enrolled in managed care. Publicly funded managed care plans have network requirements similar to commercial managed care plans.

The NYS DOH Medicaid Managed Care plan contract clause (Section 10-18) specifies the insurance carrier’s obligations to reimburse local public health agencies for specific public health services including immunizations even if the LHD does not have a contract. This requires that Medicaid managed care plans reimburse LHDs that provide immunizations to the plan enrollees without a contract, at a State determined reimbursement rate. For vaccine administration to VFC eligible children, this rate is \$17.85. Contracts may specify a different reimbursement rate.

Medicaid Managed Care model contract (refer to Section 10-18)	<a href="http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf">http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf</a>
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### Provider Credentialing with Third Party Payers

Credentialing is the process by which medical providers provide documentation to show that they are qualified to perform services according to applicable laws and health insurance plan policies. Credentialing of LHD clinicians is a required step in order for LHDs to receive claim reimbursement. Once a provider has been credentialed, the third-party payers will activate the clinician in the payer’s claims processing system.

As mentioned in the Contracting section of this document, the LHD should use an assessment of their payer mix to identify the pool of payers with which to seek relationships. LHDs may be required to complete the credentialing process to submit claims even when billing as an out of network provider.

**Credentialing Process:** Many payers have on-line services through which providers initiate the credentialing process. Many payers utilize the Council for Affordable Quality Healthcare (CAQH) provider credential profiles to streamline the process and reduce the number of credentialing processes required of a provider. CAQH is a nonprofit alliance which promotes interactions between providers and many health plans to simplify healthcare administrative functions and reduce the costs associated with these activities.

- It is recommended, and for some payers a requirement, that each clinician develop their profile with CAQH to assist in the credentialing process;

- A CAQH profile will contain specific information about a clinician including their license(s), education information, and specialties;
- Providers must submit documentation to complete the CAQH profile
- The provider will enable select insurance plans to access their CAQH data;
- Most payers require additional information before notifying the provider of acceptance of the credentials, and;
- Regular re-credentialing schedules ensure that current information is maintained.

CAQH	<a href="http://www.caqh.org">www.caqh.org</a>
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The credentialing process generally takes about three months to complete. However, there are circumstances where the credentialing process can take four or five months. Constant monitoring and follow-up is required to quickly detect breakdowns in the process.

Insurance plans may deny coverage for services rendered by a non-credentialed provider until the credentialing process is completed.

## Billing Workforce Capacity

The following section reviews major workforce functions that support the revenue cycle and discusses staff training for implementing changes and maintaining capacity in the evolving billing landscape.

### Staffing Requirements

The workforce needed for LHD billing operations depends on the claims volume. In smaller LHDs, individuals may perform multiple functions and some of these functions may be performed by clinical staff. However, the key revenue cycle functions and skill sets will be similar across LHDs. Personnel are needed for:

1. Front end scheduling and registration;
2. Billing and collection;
3. Payer electronic claims and electronic funds transfer deposit enrollment;
4. Contracting and credentialing effort;
5. Management to oversee the billing and collections function, and;
6. Information technology support for software implementation, maintenance and trouble shooting.

Front desk personnel handle scheduling and registration including:

- Schedule, cancel, and reschedule patient appointments;
- Remind patients of upcoming appointments and track missed appointments;
- Check patients in and properly document registration;
- Verify insurance and patient demographics;
- File documentation appropriately;
- Enter information into information system, and;
- Collect co-pays, deductible, coinsurance and other out-of-pocket payment amounts from patients.

Qualifications: High school diploma with some college course work; one to three years of experience in a medical office/outpatient setting, including experience with insurance regulations, third-party billing, patient scheduling, and familiarity with medical procedure and diagnosis coding.

Billing and collection personnel:

- Record or confirm data from encounter forms and charge sheet in the billing system;
- Submit claims to third-party payers;
- Review and rectify rejected claims;
- Process accounts receivable ledgers and review remittance advices to identify, correct and resubmit denied claims;
- Perform automated and/or manual payment posting;
- Process patient billing statements;
- Prepare documentation to support the write-off of uncollectible accounts, and;
- Prepare daily and weekly report for management review.

Qualifications: Associate or bachelor degree is preferred; knowledge of medical terminology, state and federal regulations, Medicaid and Medicare guidelines, compliance regulations and insurance company requirements; and experience with automated practice management information systems.

Personnel assigned to payer enrollment activities:

- Enroll the clinic in electronic claims processing and electronic funds transfer services;
  - Submit all paperwork to clearinghouse to enroll provider;
  - Submit online applications with payers to obtain insurance verification tool web access;
  - Process paperwork to receive reimbursement directly into provider bank account (electronic funds transfer payments), and;
  - Process payee address changes.
- Qualifications: Associate degree in accounting, bookkeeping or equivalent experience.

Personnel assigned to contracting and credentialing activities:

- Contact third-party payers to initiate contracting process;
  - Obtain provider contract templates from payers;
  - Review and negotiate reimbursement rates with payers;
  - Coordinate the review of the contract language with legal department;
  - Coordinate LHD contract approval process;
  - Monitor contract performance and work closely with LHD providers to manage contract implementation;
  - Verify payment information including federal tax identification number to ensure smooth revenue function;
  - Assist in the development of systems, processes and policies for streamlined contracting;
  - Ensure providers are enrolled under the LHD provider group contract;
  - Coordinate completion of provider enrollment applications and credentialing documentation;
  - Coordinate provider re-credentialing;
  - Track and maintain all necessary paperwork to credential providers;
  - Develop and maintain tracking tool to monitor all credentialing activities, and;
  - Respond to internal and external inquiries regarding credentialing activities.
- Qualifications: Bachelor degree preferred; experience with processing credentialing provider enrollment applications; and familiarity with third party payer provider relations departments.

Fiscal management personnel:

- Document and implement appropriate clinic billing policies and procedures to ensure that service fees and sliding fee discounts are applied to maximize revenue and access;
- Implement insurance verification and clinic out of pocket fee collection policies;
- Implement effective and efficient claim processing, remit posting and cash collections procedures;
- Ensure that billing processes maintain strict patient confidentiality according to Health Insurance Portability and Accountability Act (HIPAA) guidelines;
- Maintain up-to-date expertise and knowledge of healthcare billing laws, rules, and regulations;
- Monitor charge posting, billing and collection operations for compliance with established policies, regulations, procedures and standards;
- Work with IT and other staff to maintain effective fiscal management systems;
- Develop and implement control mechanisms to ensure accurate and timely billing and collections;
- Manage delinquent accounts, collections, special adjustments, and write-offs, and;
- Develop operational performance metrics and regularly analyze them to determine appropriate staffing requirements;

Qualifications: Bachelor or master degree preferred; five to ten years experience in medical billing with five years experience managing a billing operation; experience with process improvement; experience with commercial insurance, Medicare, Medicaid; and knowledge of health care billing policies, procedures, documentation and standards.

IT support staff for software maintenance and trouble-shooting:

- Support and the maintain client server and IT applications;
- Manage data center, computer network and help desk; and;
- Participate in the implementation of patient information systems.

Qualifications: Bachelor degree in computer related field; five plus years experience with procedural programming languages and database utilities required; and experience in healthcare, or insurance applications preferred. This position requires knowledge of HL-7 interfaces and SQL or other query language.

### Education and Training

Training is a key component to the overall success of LHD billing operations. In order for the LHD to be successful in all aspects of the Revenue Cycle, all administrative personnel should be trained in the billing cycle, and proper policies and procedures. Additionally, all personnel need to be trained and understand the use of their Health Information System (HIS). Clinical staff should also be trained in accurate documentation of immunizations. The use of change management techniques can assist LHDs through the process of implementing new aspects of the revenue cycle.

**Change management** is the structured approach to transitioning an organization from a current practice to a desired future practice. The process to bill third party payers or charge patients for immunization services will be a significant change for many LHDs. It is important for LHD management to understand the general concerns of staff regarding billing for immunization services, and their acceptance of immunization billing. Staff feedback may also uncover potential implementation problems. The method and information collected can be used when developing training methods and training materials.

There are several steps which can be used to assist in managing the procedural change. These steps include:

1. Develop a mechanism to capture the existing attitudes at the LHD.
2. Identify benefits of changes as well as any potential roadblocks.
3. Develop an effective communication process which addresses key concerns of staff including:
  - a. What is the reason for the change?
  - b. What are the desired benefits to be achieved by the LHD from the change?
  - c. When would the transition over to new processes occur?
  - d. Who will be involved in the change?
  - e. What steps will be taken to ensure that an effective change over occurs including training, tools, technology?
4. Create a comprehensive training and education program to ensure that all affected staff have the resources to fulfill their roles and responsibilities.
5. Consider process roadblocks and realistic solutions.
6. Allow for personnel to raise concerns about the change with a means to address these concerns to minimize the fear of change.
7. Monitor and adjust the implementation plan as required.

Management wanting to understand more about change management techniques can search for this information at the following websites:

Collegiate Project: Library of resources	<a href="http://www.collegiateproject.com/erplibrary.asp">http://www.collegiateproject.com/erplibrary.asp</a>
Collegiate Project: Featured tools	<a href="http://www.collegiateproject.com/toolofthemonth.asp">http://www.collegiateproject.com/toolofthemonth.asp</a>
Change Management: Resources and training	<a href="http://www.change-management.com/">http://www.change-management.com/</a>
Online textbook	<a href="http://www.change-management-toolbook.com/mod/book/view.php?id=74">http://www.change-management-toolbook.com/mod/book/view.php?id=74</a>
Demand Metric: Information and tools, requires free registration	<a href="http://www.demandmetric.com">www.demandmetric.com</a>

## Summary

This document describes aspects of local health department practice necessary for successful third party billing success, including the revenue cycle and the underlying foundation of successful billing practices. Each LHD will need to act on the information contained within this guide to evaluate local clinical practice and existing third party billing practice and make adjustments for optimal performance.