The Washington State Local Health Jurisdiction

Immunization Billing Resource Guide

















A Product of the Washington State American Reinvestment & Recovery Act (ARRA) Immunization Reimbursement Project Workgroup

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Washington State American Recovery and Reinvestment Act (ARRA) Immunization Reimbursement Project Workgroup Members:

Tracey Andrews Centers for Disease Control and Prevention

Michelle BalterGrays Harbor County Public HealthSusann BasshamWalla Walla County Public Health

Lynn Crist Grays Harbor County Public Health and Social Services Department

Bonnie Hall Benton-Franklin Health District

Jeannie Hampton Grays Harbor County Public Health and Social Services Department

Katherine Harris-Wollburg Washington State Department of Health

Siri Kushner Kitsap County Health District

Jan Hicks-Thomson Washington State Department of Health

Jane Kurata Jefferson County Public Health

Lucy Machowek Grays Harbor County Public Health and Social Services Department

Paula MaxwellSpokane Regional Health DistrictVeronica ShawJefferson County Public HealthJessica SyskaJefferson County Public HealthNancy WenzelWalla Walla County Public Health

Jeff Wise Washington State Department of Health



Billing Insurance: The Benton-Franklin Story

By Bonnie Hall, Client Services Manager

In 1995, the Benton-Franklin Health District (BFHD) was looking for new sources of revenue to sustain our agency. Eighty percent of our funding came from our district's cities and counties. We were experiencing the highest growth rate in the nation, but these contributions weren't keeping pace. Then the formula for funding public health was changed at the legislative level, the cities were no longer required to contribute and their contribution was replaced by a portion of the motor vehicle excise tax.

At the time, we charged five dollars for each childhood vaccination. Clients who couldn't pay

at the time of service signed a "no pay" form, and those charges were written off.

Our first objectives were to bill Medicaid for immunization and the First Steps programs, Maternity Support Services and what was then Maternity Case Management. We also wanted to begin sending monthly billing statements for clients who could afford to pay but didn't have the money at the time of service.

We planned to bill Medicare and Medicaid electronically and eventually add some private insurance companies.

To further set the stage, in those days, we occupied a drafty old building that the City of Richland owned and wanted to level for a new police station. Ice would form on the insides of the windows each winter. The health district desperately needed a bigger, better space. In 1999 we moved but we found that our "new" building was actually forty percent smaller. It had an unfinished basement with a low ceiling and a sloping floor that fed into a drain. The space had

even been used for autopsies! Such is the life of public health! With drywall, fresh paint and carpet it became our new Billing Department. Soon after moving in, we realized that we were not alone. A family of skunks lived under the building on the other side of a new wall... until we had them relocated.

Once, the sprinkler system for the property burst and flooded the office soaking boxes of billing records.





But it was Initiative 695 that caused the real trouble. It repealed the motor vehicle excise tax which had been a replacement source for the cities' contribution to public health across Washington State. The repeal took a huge bite out of district funds and our revenue crisis worsened. Our population continued to grow and it became increasingly difficult for local families to find physicians willing to accept new patients. We also experience a seasonal influx of people for agriculture. The health district started seeing more clients with insurance benefits who couldn't afford to pay at the time of service. In response, we began billing for more services, including TB, travel clinic, HIV and STD testing; HIV case management; mass flu clinics; and the First Steps services.

Initially we billed private insurances as a courtesy from a non-contract position. We then developed a billing relationship with Group Health using an MOU (Memorandum of Understanding). It was

eventually rolled into a formal contract. Now we bill Medicare, Medicaid, eight contracted insurances, and many non-contracted insurances.

Currently, we use monthly statement and invoice billing for over a thousand local businesses, food establishments, and funeral homes. Billing of clients and insurance has enabled the district to serve more people and reduce write-offs considerably. Insurance billing is now incorporated into Benton-Franklin's districtwide goals. We continue to learn new ways to improve our processes, increase our billing capabilities, and improve our contracting terms. We are constantly looking at ways to improve our fee establishment policy and review processes as well. There continues to be a great need for financial stability for all LHJs. We don't see that changing any time soon. At Benton-Franklin Health District, insurance billing is essential to the long-term sustainability of the services we provide.



"Billing is a mystery to many in public health."

"We want to be able to help people get vaccinated."

"We have to pay staff and keep the lights on too."

"We need to start thinking like a business."

"Getting agency and leadership buy-in is an ace up your sleeve."

"Give billing a try and get started."

-Washington State ARRA Immunization Reimbursement Project Workgroup Members

Disclaimer

- This booklet was prepared as a service to the local health jurisdictions in Washington State. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents. The person or persons relying upon these guidelines does so at his or her own risk.
- This document represents the collective best effort of the authors to provide a guide on how to bill insurance plans in Washington State (specifically Medicaid, Medicare and private insurance carriers) for immunization services. It is not a contract and is not legally binding on the entity providing it.
- Compliance with the guidelines found in this document does not guarantee that the insurance carrier, public or private, will pay all or any portion of the cost of the immunization.
- The local governments that have generated, distributed or provided this
 document do not control whether the insurance carrier, public or private,
 will pay all or any portion of the cost of the immunization and does not
 guarantee payment by the insurance carrier will occur.
- The local governments that have generated, distributed or provided this document are not responsible for any out-of-pocket expense or cost related to an immunization that is not paid by the private or public insurance carriers or that arises out of the occurrence of a patient receiving an immunization.
- This booklet was current at the time it was published. Billing processes and websites change frequently.

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Introduction and Background

The Local Health Jurisdiction Immunization Billing Resource Guide is an outcome of the Washington State American Recovery and Reinvestment Act (ARRA) Immunization Reimbursement Project. It was developed by the Washington State Immunization Reimbursement Workgroup during a series of meetings held between May 2010 and August 2011.

The Workgroup consisted of representatives from the Washington State Department of Health (DOH), the Centers for Disease Control and Prevention (CDC), and five of the Local Health Jurisdictions (LHJs) who are pioneering efforts to bill private health insurance plans across the state:

Benton-Franklin Health District
Grays Harbor County Public Health and
Social Services Department
Jefferson County Public Health
Spokane Regional Health District
Walla Walla County Public Health

An initial task of the Workgroup was to survey Washington counties about their current billing practices. It developed and distributed *The Survey of Local Public Health Agencies in Washington State of 2010*ⁱ, which was completed by 92 percent of the 39 counties in Washington. The survey found that while nearly nine in ten Local Health Jurisdictions (LHJs; agencies) offer immunizations,

i Available at http://jeffersoncountypublichealth. org/index.php?publications-data-resources



only one-third bill private insurance for this service. It also identified several barriers that LHJs encounter while attempting to bill insurance plans for immunization services. Lack of knowledge—of billing private health carriers and Medicare in particular—was identified as a significant barrier to obtaining reimbursement for care of insured clients.

Public Health serves clients with public, private or commercial insurance. Insurance plans have an obligation to pay for covered services for their members. But until recently, health departments and districts absorbed the cost of providing care to insurance plan members. As traditional funding streams to support LHJs shrink, agencies must look elsewhere to ensure vaccines are readily available and the public health safety net is maintained.

Insurance plans recognize that preventive care offers the best approach to protecting the health of beneficiaries and reducing their health care costs.



Yet, economically stressed families are facing increased difficulty in meeting out-of-pocket costs for immunization. Billing is the bridge between improving access to care for clients and expanding partnerships between LHJs and the larger healthcare system.

LHJs may be increasingly motivated to bill insurance plans in order to meet the needs of their clients and to compensate for declining revenue. This guide presents instructions, tips, and resources to support public health billing programs. The first chapter outlines an approach to exploring the potential of insurance billing to benefit your organization and community. Chapter 2 is an overview of important billing basics. The remaining three chapters contain information specific to billing private insurance, Medicare, and Medicaid. Appendices include forms, policies, fee schedules and other resources that LHJs in Washington State have developed in the course of billing insurance carriers for immunization and other services. Throughout this resource guide, there are links to websites and documents with detailed information about a wide variety of billing-related topics. Also included are the Internet addresses of many organizations that serve the billing needs of health care providers, including LHJs.

This Local Health Jurisdiction Immunization Billing Resource Guide is primarily intended for Washington State LHJs in the early stages of billing health insurance, especially private plans. It may also be useful as a reference and training resource for seasoned billers. Finance managers, nursing directors, and billers are most likely to find the guide useful, as would anyone interested in a better understanding of how billing works within a decentralized public health care system.

Funding for the development of this guide was provided through the Centers for Disease Control and Prevention (CDC) Washington State Department of Health (DOH) ARRA Immunization Reimbursement Project Grant No. 3H23IP022548-0751. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC or DOH.

Chapter 1

Set the Stage



1. Set the Stage

"Governmental public health departments are responsible for creating and maintaining conditions that keep people healthy."

Think Like a Business

Increasingly, local health jurisdictions (LHJs or agencies) must balance goals—such as preventing communicable disease—with the practical aspects of running a business. Economic factors have changed the financial landscape for most, if not all, LHJs in Washington State. In turn, agencies have responded in ways that reflect the unique nature of communities they serve by:

- Reducing costs
- Creating efficiencies
- Charging more
- Seeking new sources of revenue or funding
- Scaling back or discontinuing services, hours, or programs
- Expanding existing programs and/or creating new programs or services

This manual is a guide to billing Medicare, Medicaid, and private insurance for immunization, but these activities do not exist in isolation. They

i From Taking Care of Business: A Collaboration to Define Local Health Department Business Processes. Copyright 2006 by Public Health Informatics Institute. All rights reserved.



fit into a bigger picture of planning, budget and policy development, organizational objectives, grants, programs, and community priorities.

Billing is one way to think and act more like a business. Billing allows health departments and districts to identify and tap into existing sources of revenue to survive, even thrive, through tough economic times when people often need care most. Patients with private or commercial insurance pay premiums for health care benefits covered by their health plans. It only makes sense that health agencies would bill commercial insurance for the health care they provide to plan members.

Vaccinate without Losing Your Shirt

To stay financially viable in the face of changing economic circumstances, LHJs are rethinking many aspects of how they do business. They are working to understand what kind of services they deliver, who gets those services, and what sources of payment are available to help cover the costs. Billing for services is one way to offset the costs of services. The choice to bill, or to bill

more comprehensively, must be integrated with other important decisions such as, "How do we determine costs?" or "How do we set fees?" With so many interrelated issues, it can be difficult to know where to begin.

The following sections address five aspects of establishing a sustainable billing program:

- Public Health Recommendations
- Business Processes Analysis
- Assessment of the Community and Clients
- Costs
- Fees
- Mentoring

Public Health Recommendations

According to the Washington State Public Health Improvement Plan for 2010ⁱ, public health is at a crossroads and must transform to:

- Maintain past successes of communicable disease prevention and responsiveness to new threats such as pandemic influenza (H1N1).
- Confront emerging challenges of chronic disease and preventable illness.
- Use increasingly limited



resources effectively.

• Provide measurable public health service.

In addition to building a culture of accountability and quality improvement, the plan's overall recommendation is that we "refocus the work we do to better respond to the changing threats to public health. While maintaining communicable disease capacity, we will focus efforts to promote healthy starts and wellness and better partner with the healthcare system to improve access [emphasis added]."

Health agencies have provided services to members of their community for many years. They provide access to services for clients with public and private or commercial insurance. In the past, health departments and districts absorbed the cost of providing care to insured patients. They cannot absorb those costs any longer. Insured patients have benefits covered by their health plans. Health plans have an obligation to pay for those services. Billing is the bridge

i <u>www.doh.wa.gov/PHIP/doc/</u> partner/phip/10phip.pdf



between improving access to care for clients and expanding partnerships between LHJs and the larger healthcare system.

Business Process

Understanding the business processes for the services your LHJ provides is the first step in developing the kind of information system that will meet the business and billing needs of your department. Each health department must thoroughly understand the steps involved in providing a service—from checking a client into the clinic, to delivering the service, to billing and paying staff. The people involved in each step associated with delivering the service should collaborate on an analysis of the business

process. This is the foundation for deciding what information system is the best fit for your business needs.

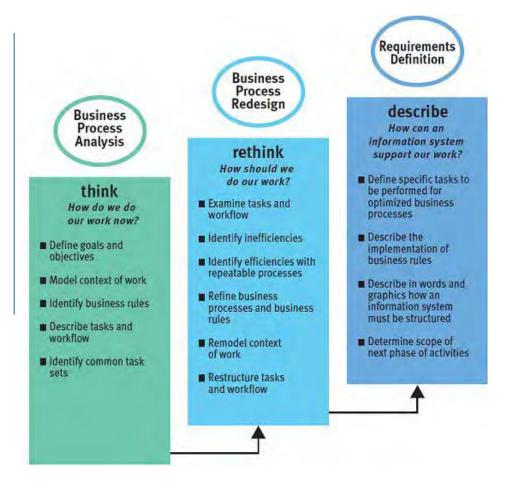
For more information about conducting a business analysis, we recommend the "Collaborative Requirements Development Methodology" contained in *Taking Care of Business: A Collaboration to Define Local Health Department Business Processes*, a free online publication of The Public Health Informatics Institute and the National Association of County & City Health Officials (NACCHO).

i Public Health Informatics Institute. (2006).

Taking Care of Business: A Collaboration to Define
Local Health Department Business Processes.

Decatur, GA: Public Health Informatics Institute.

Figure 1.1.
Public Health
Informatics
Institute
Collaborative
Requirements
Development
Methodology



Taking Care of Business describes the three steps of Collaborative Requirements Development Methodologyⁱ which brings staff together to "think through the tasks that are performed to meet specific public health objectives (analyze business processes), rethink the tasks to increase

effectiveness and efficiency (redesign business processes), and describe what the information system must do to support those tasks (define system requirements)."ⁱⁱ

This analysis is ideally accomplished before billing software or related information systems are acquired.

i Taking Care of Business: A Collaboration to Define Local Health Department Business Processes. Copyright 2006 by Public Health Informatics Institute. All rights reserved.

ii http://phii.org/resources/doc/Taking_Care_of_Business.pdf#search="taking care of business"

Billing System Selection

Like everything else, health care billing is increasingly reliant on interrelated software and computer systems to manage records and conduct transactions. Billing on paper, though still possible, is on its way out. The Collaborative Requirements Development Methodology will enable you to answer the question, "What do we want our billing system to be able to do?" The next step is to identify a system that will do those things well and affordably.

You may also want to check with other public health departments or providers in your area to see what systems they use. First hand information from them about what works well and what doesn't can be very useful. Request a system demonstration and be sure to ask about flexibility, maintenance, and expansion options. The system you select should be a good fit for your organization now and be flexible enough to expand and grow with you.

There are numerous factors to consider in selecting a billing system. Traditional billing software operates on computers in your office. Application service provider (ASP) or "cloud-based" systems process data at the software company's data center or another remote location. Most Health Insurance Portability and Accountability Act (HIPAA) compliant systems have the capacity to balance accounts and track receivables, co-payments, co-insurance, allowable fees, and coding. Some are tied to a specific clearinghouse (an entity that aggregates



and transmits claims information). Others offer a choice of clearinghouses. Some systems can support other business aspects for the LHJ besides billing.

In addition to system capacity and features, consider the quality of customer service that would be offered. When you call with a question, how soon will someone pick up the phone? If you have a technical issue, will you reach someone with the knowledge to answer? Inquire about the company's staff turnover rate. Request a trial period to ensure the system meets expectations after purchase. Connecting with others who use the system can provide information about working with the vendor.

Be sure to consult your LHJ's bidding procedures and local codes when developing a protocol to evaluate potential candidates. Before making your final selection, check the references of each company under consideration.



Community and Clients

A successful LHJ billing process for immunization includes consideration of the unique attributes of your community and clients.

Assess your community:

- What are our demographics and how are they changing?
- What underserved populations are present?
- How strong is the current demand for LHJ services? How is it likely to change?

- What are our priorities as a health department?
- What is the community support for those priorities?
- Assess your client base:
 - Who is requesting services?
 - Who is receiving services?
 - How many insured clients are you serving?
 - Which health insurance plans are carried by clients?
 - Is cost an obstacle to care? For whom?

Costs

All relevant costs must be identified and analyzed before a fee schedule can be created. A strong cost assessment includes all expenses associated with delivering the service and can help determine a reasonable fee schedule to cover or off-set those costs.

Three interactive "cost calculator" spreadsheets developed for private clinics by the Arizona Chapter of the American Academy of Pediatricsi may serve as models for assessing LHJ costs related to vaccinations. They are reproduced in Appendix V and available for download from Jefferson County Public Health at http:// <u>jeffersoncountypublichealth.org/index.</u> php?publications-data-resources.

- Vaccine Inventory Value Calculator used to calculate the actual dollar value of your inventory of vaccines at any given time based on purchase price."
- Vaccine Product-Related Cost Calculator—2011
- Vaccine Administration Cost Calculator

Fees and Fee Structure

It's important that the benefits of billing for services outweigh the cost and effort of billing. It is also important for the health department to retain the flexibility of providing or assuring services to the community and for clients who may have limited resources. Both goals are attainable through an adequate fee schedule and a policy for using a sliding fee scale when needed.

All clients and plans are charged the same "Usual and Customary" (U & C) fee for the same type of care. In the past, U & C fees were often set as low as possible in order to maximize access. Maximizing access remains a primary public health objective, but U & C fees should be set and structured differently in connection with an immunization program designed to both maximize access and recoup costs.

Setting the fee schedule at too low a rate undervalues the care being provided and sends a false message to clients and insurers about what it costs the health department to deliver the service. The cost of delivering the service in the health department draws on alternate fund sources (e.g., tax dollars, public and private grants, volunteers etc.,), but that does not change the cost to deliver the service. It is important that fees reflect the full cost of providing the service.

Conversely, fees set too high can turn away clients and insurers. Ideally, fees would cover all program costs but not generate a profit. In setting

i The calculators were originally created by AzAAP Council Co-Chair Dr. Jeff Couchman. ii Please note the "Inventory Value" of state supplied vaccines could be represented by actual costs (\$0). Alternatively the cost calculator could be used as a forecasting tool for situations where state supplied vaccines are anticipated to be in short supply or unavailable.

fees, it's important to recognize the LHJ role as a public safety net and avoid direct competition with private businesses whenever possible.

The question, "What is the minimum we have to charge to supplement this program and not create a barrier to folks?" then becomes, "What does it actually cost to sustain this program? How can we set and structure fees so that costs are recouped while access to care is maintained?" Checking with other health departments can help your LHJ get a sense of what an appropriate fee schedule may be. Reviewing information from the American Academy of Pediatrics on the cost of immunization may also help give you a sense of how to calculate the cost of the service and set an adequate fee schedule.

Reimbursement may vary from health plan to health plan, and most are reluctant to reveal their reimbursement rates. Before contracting with an insurer check with other health departments to see what they are being reimbursed by payers. Remember, your fee schedule will be a driver behind what your reimbursement will be. Make sure you know as much about reimbursement rates as possible before setting your fee schedule.

A fourth cost calculator from the Arizona Chapter of the American Academy of Pediatrics, the "Vaccine Cost and Payment Comparison Sheet" (see Appendix V or download at http:// jeffersoncountypublichealth.org/index. php?publications-data-resources), identify significant gaps between existing costs and fees which support the need to increase or reduce fees.

Consider linking any proposed fee schedule with a new or revised policy to allow sliding fee scale discounts for specific populations (for example, see Appendices C, D, E, and F). If your agency will be billing private insurers for the first time, joining additional insurance networks or improving access in some other way, project how client numbers and LHJ services will change over time.

In reality, many LHJs set their fees lower than the break-even point and compensate for writeoffs with funds from other sources. As the "other sources" that support immunization services grow scarce, billing private insurance for services to their members can help make up the difference.

When an LHJ enters a billing relationship with a private insurer and becomes an in-network provider, the plan can increase access as more members are likely to use the clinic for services. Program revenue may increase because the majority of private plans reimburse at a higher rate than Medicaid. Also, generally, private insurance allows a provider to bill administration fees at a higher rate. This includes when disease consultation is provided along with vaccines that contains multiple antigens (e.g., MMR, DTaP, etc.). LHJs that that provide these services to insured patients can bill private insurance for these allowed fees and expect to be reimbursed. This could significantly increase the revenue generated from immunization services. (Note: The Washington State Medicaid Program does not currently recognize these codes. They can be used for non-Medicaid VFC eligible children, but the total of all the multiple administration

fees cannot go over the federal VFC vaccine administration cap set for WA at \$15.60 per dose. More information on this topic is covered in Chapters 3 and 5.

Tapping the private insurance industry for payment of services being rendered to their members is critical. The combination of higher fees and reimbursement, policies to protect vulnerable populations, and a growing clientele can improve the overall financial outlook for an LHJ.

Mentoring

Most health departments and districts bill Medicaid for vaccines administered to clients covered by the Medicaid Program. Some health departments don't bill public or private insurers for services. Some bill both public and private insurers. There are staff in LHJs across the state with significant knowledge and experience with billing public and private insurance. The environment of public health is changing, and the value of billing is becoming more apparent. It is more important than ever for health



departments to expand their knowledge about billing and create a resource pool and information sharing network to support one another in taking advantage of opportunities to boost revenue through billing for services they provide.

Because the world of insurance billing is constantly evolving, a public health information sharing and mentoring network is important to support the initiation and sustainability of billing by health departments. It's easier to build or maintain skills, and to find solutions to problems, when you connect with other billers in the wider LHJ community. Resources for LHJs include talking with colleagues from other jurisdictions and visiting their billing departments. Creating a more formal network, such as a public health email user group or setting up conference calls from time to time, facilitates the exchange of billing information. Other resources include local billing or office manager workgroups, conferences and vendor presentations. Vaccine manufacturers may also have coding information specific to their products and may be able to assist.

Vaccines for Children (VFC)

The VFC Program is a federally funded program to provide vaccines for the benefit of children who otherwise might not be vaccinated due to inability to pay. Children eligible for vaccine supplied through the VFC Program are Medicaid eligible, uninsured, 'underinsured' (have insurance that does not cover all required vaccines), or are American Indian/Alaska Native.

Figure 1.2. Sample CMS-1500 claim form for the DBA



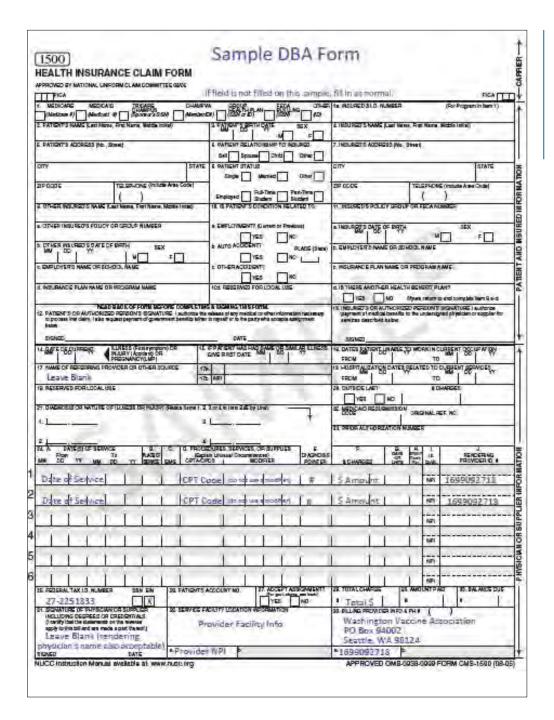


Figure 1.3. Sample CMS-1500 claim form for the DBA



The VFC Program ensures that all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available to enrolled providers for all eligible children less than 19 years of age.

Washington's Universal Vaccine Supply Policy

From 1993 until 2009, Washington's Universal Vaccine Supply Policy allowed the use of state funds to purchase ACIP approved vaccines off of the CDC contract to benefit children ineligible for the VFC Program. The policy created a single vaccine purchase and distribution system for all children in Washington less than 19 years of age, regardless of insurance status. Washington State continued its Universal Vaccine Purchase Policy through legislation creating a private non-profit organization, the Washington Vaccine Association (WVA), in 2010. The WVA now collects assessments for vaccine purchases for children who are not eligible for the VFC Program.

Washington Vaccine Association (WVA) and the Dosage Based Assessment (DBA)

Through the Washington Vaccine Association, commercial health plans, insurers, and other payers now pay an assessment to support the Washington State Childhood Vaccine Program's vaccine purchases for insured children less than 19 years of age. Health plans are assessed a fee based on each vaccine administered to a child covered by the plan. This is called the Dosage Based Assessment or DBA. The Washington Vaccine Association Board sets the assessment rate. The WVA collects the assessments from the payers and transfers the funds to the state. The DBA does not apply to vaccines for Medicaid clients.

Why the DBA is Important

Through the State Childhood Vaccine Program, the state Department of Health buys vaccines at federal contract rates and distributes them to physicians, clinics, hospitals, and other providers at no charge. The vaccine can then be administered to any child less than 19 years of age who comes in for a vaccination.

Providers continue to receive vaccines at no charge from the Washington State Department of Health while clinics avoid the financial and staffing load necessary to purchase private vaccine on their own. Providers are not required to maintain separate inventories or accounting processes for public and private purchase vaccines.

Billing and the DBA Process

LHJs are encouraged to bill insurance plans for the costs of administering vaccines to insured patients. They are also encouraged to complete the DBA process so health plans can be assessed for vaccines delivered to their members by the health department. The process involves submitting two different CMS-1500 forms to the insurance plan. The first form is completed to account for the administration of the vaccine, office visit, and other charges incurred by the LHJ. The second accounts for the use of state-supplied vaccine only and constitutes the WVA assessment to reimburse the state.

Steps to the DBA process include:

- 1. Submit the usual CMS-1500 form for the administration of the vaccine, office visit, and other charges, just as you always have, but without the vaccine codes and modifiers.
- 2. Submit a second CMS-1500 form that contains the vaccine codes and the dosagebased assessment charges, which you'll find on the WVA Assessment Grid (available at the website below).
- 3. Submit both forms to the appropriate health plan, insurance company, or third party administrator (TPA), not to the WVA.
- 4. Electronic billing systems can be set up to create both the service fee claim and the dosage based assessment. Contact your billing system vendor for help with this. Your vendor may contact the WVA for assistance as well.

What You Should Do

Local health jurisdictions are encouraged to complete the dosage based assessment when they vaccinate insured children. This supports the funding of the universal childhood vaccine program. LHJs, as safety net providers, are not required to complete the dosage-based assessment. If your LHJ can bill using the dosage based assessment method, you should.

Related Resources

Additional information can be found on the WVA web-site at www.wavaccine.org/ wavaccine.nsf/pages/for-providers.html

You may also contact the WVA directly for information and technical assistance at 1-888-928-2224.

The WVA Assessment Grid: www.wavaccine. org/wavaccine.nsf/pages/AssessmentGrid.html

A DBA sample form: www.wavaccine.org/ wavaccine.nsf/documents/DBAFormSample. html/\$File/DBA Sample%20Forms.pdf

Frequently asked questions: www.wavaccine. org/wavaccine.nsf/pages/fags.html

Forms and charts: www.wavaccine.org/ wavaccine.nsf/pages/forms-charts.html

For more information regarding the Washington Vaccine Association (WVA) go to www. wavaccine.org/wavaccine.nsf/pages/home.html

Chapter 2

Billing Basics





2. Billing Basics

National Provider Identifier (NPI)

The Heath Insurance Portability and Accountability Act (HIPAA) requires heath care providers to obtain a National Provider Identifier (NPI) for use in standard HIPAA transactions including insurance billing. Providers obtain an NPI from the Centers for Medicare and Medicaid Services (CMS). The NPI number never expires and will not change as the result of job or relocation. It is intended as a unique identifier for all health plans to utilize.

With the exception of atypical providers, Washington Department of Social and Health Services (DSHS) requires all health care providers (individual, organization, and subparts of an organization) to obtain an NPI if they submit electronic and paper claims. NPI numbers are essential to most insurance enrollment and billing processes. To learn more about the NPI, visit the NPI website at http://hrsa.dshs.wa.gov/dshshipaa.

The CMS-1500 Health Insurance Claim Form

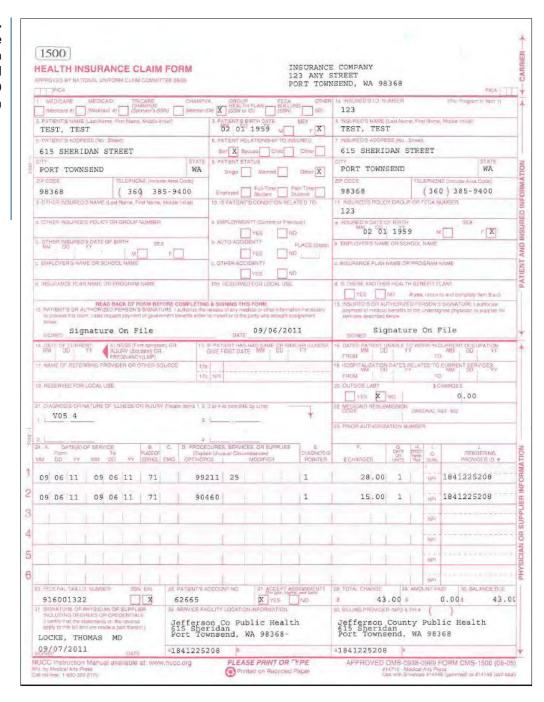
The CMS-1500 form is the standard for submitting health insurance claims on paper to private insurers, Medicare and Medicaid. Instructions on completing the form can be found online with various insurance carriers and the Centers for Medicare & Medicaid Services (CMS) such as www.cms.gov/MLNProducts/downloads/form_cms-1500 fact sheet.pdf.

In order to purchase claim forms, contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies in your area, and/or office supply stores. Each of these vendors sells the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc). The only acceptable claim forms are printed in Flint J-6983 Red OCR (or exact match). The particular ink color enables the completed forms to be scanned for data while excluding the form elements. Photocopies of the CMS-1500 form cannot be used for submission of claims, since copies may not accurately replicate the scale and OCR color of the form.

The National Uniform Claim Committee (NUCC)¹ releases an annual, updated version of its 1500 Health Insurance Claim Form Reference Instruction Manual. To view a copy of the current CMS-1500 Claim Form go to: www.nucc.org, then click on "1500 Claim Form" at the top of the screen.

i www.nucc.org

Figure 2.1. **Example** of a Completed CMS-1500 **Form**



Current Procedural Terminology (CPT®)

Current Procedural Terminology (CPT)i is the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. Since everyone uses the same codes to mean the same thing, they ensure uniformity. Codes identify the immunization and other services provided by the LHJ on claim forms and other billing materials. Vaccines, administration, and office visits are reported using separate codes. In contrast to the thousands of CPT codes in existence, about seventy codes related to immunizations are referenced in this guide. Many are found in Chapter 4, Billing Medicare.

Explanation of Benefits (EOBs, EOMBs and ARs)

After the insurance carrier receives and processes a completed CMS-1500 form, it sends the LHJ a status report called an Explanation of Benefits (EOB). There is no standard format for how insurance companies report payment information on their EOBs. EOBs typically include a listing of the services provided, the amount billed, any insurance payments and the amount due from the patient. The EOB is sometimes accompanied by an insurance benefits check.

Medicare supplies a similar report, the Explanation of Medicare Benefits (EOMB), and Medicaid sends Remittance Advices (RAs, also called 835s). These forms all accomplish the same purpose—to explain the status of a claim.

More specifically, an EOB, EOMB or RA is likely to include:

- **Negotiated or Allowed Amount:** The in-network rate that was negotiated for the service. Otherwise this will be the recognized amount under the member's plan.
- Paid Amount: The actual amount paid by the insurer for the item or service, after coinsurance and deductibles are factored in.
- Copay Amount: Identifies the amount the patient owes as a copayment for this service.
- **Deductible Amount:** This is the amount of the patient deductible that applies to the "submitted charges" or the "negotiated or allowed amount."
- Pending or Not Payable: Portions of the claim amount may be pending or is denied.
- **See Remarks or Message Codes:** These explain the reason(s) that an amount is pended or denied.

Don't hesitate to contract an insurer with questions about how to interpret an EOB or its equivalent.

i Current Procedural Terminology CPT® is registered trademark of the American Medical Association.

Denials

Unfortunately, some number of the "remarks" or "message codes" you receive will likely indicate denial of payment. Denials occur for many reasons. They are a fact of life and will happen regardless of how carefully you submit the initial billing. Some denied claims will ultimately be paid if they are rebilled. Others will not.

The most common reasons LHJs are denied payment are:

- no coverage on date of service
- not a contracted provider
- not a covered service
- coding errors
- applied to deductible

A denial doesn't necessarily translate into a writeoff. The key is to understand the reason for the denial, and to correct and resubmit the claim as appropriate. Once you become accustomed to filing claims, interpreting denial codes won't be that difficult and you'll generally know what to expect of each insurance company. If you receive a denial from a contracted carrier, definitely follow up on it.

Interpreting the Remarks or Message Codes

If an insurance plan denies payment of the claim, it will list one or more reasons for this in the form of a remark or denial code on the EOB. Often message codes are listed on the back page of the EOB document. Some claims are only partly denied. In these situations, a client balance remains in the form of a co-pay or cost share that can be billed to the patient or, if necessary, written off.

Don't worry if the denial code, and even the explanation of the code, doesn't seem to make sense. This can happen with some frequency, at least initially. Perhaps the best and quickest way to get to the bottom of a denial is to call the insurance plan and ask for help interpreting the message code. A provider services representative can also advise you of what, if anything, needs to be resubmitted.

Re-bill Opportunities

Sometimes you will find, as you scan through a payment voucher or EOB, that the same charge for one patient was paid while the identical service for another patient was denied. Learn the



reason for this. If it occurred because the clients had different coverage plans, it should show a patient billable balance for one and there is nothing further to rebill. Bill the patient for the balance according to your LHJ's policies.

If the EOB calls for a provider write-off, be sure you understand the reason and verify it against your contractual agreement before writing it off. Sometimes a claim is denied incorrectly and you can request an appeal or reprocessing of the claim.

Things Change

Make a note of other types of inconsistent claims processing and also question them. Occasionally you will start seeing denials for care that have previously been paid by the same carrier. This can happen as a result of internal changes to a company's claims processing system. If the denial doesn't look right, ask about it and resubmit the claim if appropriate.

By working your denials, you will become familiar with how each insurance company processes claims. You will learn which denials can be resubmitted for payment, and what needs to be written off or billed to patients. Learning this process well may allow you to collect the patient balance from the clients at the time of service.

Clearinghouses

Electronic medical billing has many potential advantages over paper, especially time savings. For agencies billing multiple plans, a clearinghouse

can improve and streamline the claims submittal process still further. Rather than submitting claims to each payer separately—including private insurance, Medicare and Medicaid—the LHJ transmits all claims to the clearinghouse which checks them for errors and efficiently and securely transmits them to the appropriate carrier for payment.

Any clearinghouse should provide:

- Rapid claims processing and reimbursement – often in 10 days or less
- Rapid identification of claim errors
- A single location to manage electronic claims for all payers
- Easy Internet and telephone access to knowledgeable support

Many clearinghouses can also provide:

- Eligibility verification
- Electronic remittance which updates your accounting automatically
- Claim Status Reports
- Printed Claims Have out of network ("nonpar") claims automatically dropped to paper but still be able to track them electronically
- Patient statement services
- Personal training and support provided by billing experts
- Affordability

If you are unsure whether your agency would benefit from the services of a clearinghouse,

consider a trial period with a clearinghouse that offers a month to month subscription option. Contact customer service in advance and ask for a quick tour of their control panel—the location online where you'll be managing your claims. Make certain that claim errors and rejections are reported in plain language, not as shorthand numeric codes.

"Free" may not mean best value or even lowest cost over the long run. Decide whether you need full service help or help with only a portion of the process. You'll find that clearinghouses run the gamut between "spoon fed" to "bare bones." In between these two extremes are integrated billing systems that utilize a clearinghouse while retaining some of the work in-house. Be sure to observe your organization's bidding and contracting policies before making any commitments to a clearinghouse that charges for its services.

Office Ally (www.officeally.com) is a full service clearinghouse offering web-based billing submission services free to providers. Office Ally has the ability to electronically submit claims to over 500 participating health plans. Its features include:

- An easy-to-use browser-tool allows direct data entry of claims.
- Claims for most health plans can be transmitted and tracked in one place.
- Claims can be submitted at any time, day or night.
- Claims from all practice management software packages are accepted.



Eligibility Verification

Health insurance membership cards contain important information and it's advisable for LHJs to retain copies of them in client files. However, membership cards do not necessarily ensure that a person is eligible to receive healthcare benefits. Since lack of eligibility is a primary reason why insurance companies reject claims for reimbursement, it's essential to verify a client's insurance status before they are seen. If you don't verify eligibility in advance of care, and it turns out that the client doesn't have adequate coverage, the only options are to seek payment from the client or write off the expense of providing care.

Eligibility verification should also include a determination of applicable deductibles, copay, co-insurance and other requirements and limitations. Oftentimes, clients are mistaken about the details of their coverage(s). If a client belongs to more than one plan, an online database will help you recognize this.

To determine current eligibility, consider subscribing to one or more online databases such as those maintained by *One*HealthPort (www.onehealthport.com) or the Council for Affordable Quality Healthcare (CAQH) (www.caqh.org).

The *One*HealthPort and CAQH databases were designed for sharing clinical information securely and are free to use. They give provider organizations online access to major local health plans, hospitals and other services—through one website and one common security umbrella. *One*HealthPort is also a useful resource for accessing insurance benefits and claims information for a variety of insurance carriers.

Before participating in an online database, an LHJ will need to identify one person to serve as the account administrator. The administrator will have the authority to add multiple users as needed. He or she will obtain a single digital ID to sign on across all participating insurance company

sites. Participants are required to enter into a common contractual framework that addresses HIPAA requirements and other information sharing issues.

You can also access eligibility verification information directly from private insurance company websites. This may be a preferred option if your LHJ interacts with only a few companies and whenever there is a problem with one of the online databases you typically use. Request log in information for each company well before you're likely to need it. If all else fails, don't hesitate to pick up the telephone and request eligibility information from a provider services representative.

The accuracy of every database has certain limitations but most are updated in near real time. In any case, eligibility verification is no guarantee of payment. End results may be different from what is listed in the database.



Chapter 3

Billing Private Health Insurance





3. Billing Private Health Insurance

Introduction

There are nearly thirty private health insurance companies and over eighty third party administrators operating in Washington State. Many insurance plan members look to LHJ clinics for healthcare services—immunization in particular. Billing relationships with private insurance companies can have a significant impact on an LHJ's bottom line and enhance its ability to consistently support the health and well being of the community.

LHJ clinics may provide healthcare to populations that private insurers are less accustomed to serving. For example, when a privately insured family is new to an area and lacks a medical home, an LHJ may provide the types of services that are needed right away. LHJs are frequently

the primary resource for immunization at backto-school time. When a parent or guardian is notified that a child lacks a particular vaccination, it may be impossible to get into a clinic right away. In light of this, schools in some areas routinely refer parents to health departments or district facilities.

In its role as a public safety net, LHJs benefit underserved populations. LHJs also benefit insurers by enhancing access to care. Improved access translates to plan members who are better protected from communicable diseases and, over time, reduced health care costs for payers.

LHJs face no restrictions on which companies they can bill, but many private health insurance companies are unfamiliar with the work of LHJs in Washington State and may be hesitant to reimburse the costs of care. Since LHJ billing of private insurance is in its early stages, payers may have little or no information on how many or how frequently their members use public health. They may not understand how agencies pay for the services they provide or what those services truly cost.

If billing insurance carriers becomes a priority for your organization, three questions to ask include:

- Will the benefits of billing outweigh the costs?
- Will the LHJ bill all, or only a select few, private health insurance carriers?
- Will the LHJ contract with any of the insurance companies it bills?

Choose to Contract/Not Contract

Learn which private health insurance plans are most common in your community by asking clients who access your services what health plan(s) they carry. Then, consider becoming an "in-network" provider by establishing contracts with one or more of the most common plans. It may not be worth the effort to evaluate and process a contract if a company insures only a few of your clients. The number of clients needed to support the contracting process is something that each LHJ must decide for itself.

Contracts offer legal protections for the company and for the LHJ. They also help ensure a certain standard of care for your clients. Contracts usually, but don't always, establish higher rates of reimbursement for in-network providers. Ideally, allowable reimbursement amounts would be 100 percent of the LHJ's Usual & Customary fees. For each immunization or service, the contract will also determine how the final paid amount is calculated. The write-off amount is the difference between your fee and the contracted allowed amount. The contract language will determine whether the difference between the allowed amount and the paid amount can potentially 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 allowed amount (\$16), then you may be able to charge the patient the remaining 20 percent (\$4). You

must bill established fees across the board to everybody, patients and insurers alike. Then, your contracts will dictate your required write off amounts and what balance you're allowed to bill the clients (the "balance bill").

When you approach a private health insurance company about contracting with your LHJ, you are beginning a new relationship with that business. Your first stop for information will likely be the company website. Look for a link to the Provider Relations, Health Plan Quality Assurance or Claims Management Departments, read through the information and then pick up the telephone. Call the company and ask, "How do I work with you? Is it best to have a contract with you?" Some company representatives may be able to explain the advantages and disadvantages of having a contract.

Be prepared for carriers to express reluctance to contract with your organization. This may happen when a company lacks familiarity with public health and isn't aware that your LHJ provides care to its members. If this is your experience, don't give up. If the first answer is "no," call back





and talk to more people. Educate each provider relations contact on the services you provide to their members and why. For example, "We're seeing more of your (plan) clients because they can't get into a clinic in a timely way. You have underserved plan members in this community. Here is how we can help you make sure your members receive covered services..."

When you are ready to proceed with the contract development, request a copy of the appropriate standardized contract—often called a Provider Services Agreement. Ask if they have contracts tailored to public health. Specifically ask for the current fee schedule as well. Companies may be reluctant to disseminate their current fee schedules. If you don't receive the fee schedule even after specifically asking for it, send another request accompanied by a spreadsheet containing your top CPT codes¹ and descriptions. Ask the company to complete the spreadsheet by adding the reimbursement rates for those codes.

i CPT copyright 2011 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Consider the following questions while deciding whether or not to contract with an insurance carrier:

- What are your agency billing priorities?
- How many plan members do you see regularly?
- Which programs or services do those clients utilize?
- What experiences have other LHJs had in contracting with this provider?
- Are the proposed reimbursement rates adequate to cover costs?
- Can your agency manage the time lag for reimbursement?
- Would the benefits of contracting outweigh the disadvantages?

Provider Service Representatives

The process of billing private health insurance companies isn't necessarily an impersonal one. Questions will arise that are specific to your LHJ and it's beneficial to know who to call when you need important information quickly. Develop at least one contact—a key person in Provider Relations, Health Plan Quality Assurance or Claims Management Department—who is your "gold mine" for information. That contact will vary from plan to plan.

Some companies are organized by service or provider type. From the start, you may want to request a specialist with expertise in serving LHJs. Eventually you should be able to contact company representatives more or less directly and avoid the general customer service contact numbers and email addresses altogether.

Contract Basics

A contract between an LHJ and a private insurance company will contain elements or guidelines on topics such as:

- Standard of care
- Accessibility
- Insurance
- Quality management
- Records
- Payments, underpayments, co-payments, coinsurance, deductibles, overpayments
- Audits
- Coordination of benefits
- Excluded services



Usually agreements or contracts include guidelines that are explicitly stated. Additional guidelines are not spelled out in the agreement itself but, instead, are incorporated as exhibits or by reference.

Carefully consider all of the contract exhibits and addendums which may include provisions addressing:

- Credentialing responsibilities
- Fee schedules
- Legislative and regulatory requirements

Obtain and review all of the guidelines and other documents referenced in the contract.

Contract Review

Provider Services Agreements ("contracts") impose billing requirements, provider obligations, payment points and other terms which vary from company to company. Make a photo copy of each prospective contract, highlight what works, cross-out what doesn't, and write notes in the margins. Use this version as a reference in your negotiations.

As you review a prospective contract, consider how the contract terms would be implemented within your organization. For example, if your agency has a small staff to handle immunization and billing through the busy flu season, make sure the contract allows enough time to catch up with claims once the push is over.



The fundamental question that most LHJs ask while considering a contract is, "Can we afford to accept the reimbursement rates that the carrier is offering?" "Preferred," or "in network" contracted providers, are reimbursed according to rates set by the contract and listed in the insurance company's fee schedule.

Pay particular attention to all contract language related to reimbursement. The ideal provision will indicate that services are to be paid at the rates submitted or "as billed."

Ask your legal advisor(s) to determine if the contract is consistent with all applicable laws. Many insurance firms operate in multiple states and their contracts may not be fully consistent with the laws of Washington State.

Negotiations

Insurance companies have standard provider agreements that they may be reluctant to altereven in situations where the contract language or terms are clearly inappropriate to LHJs. Each agency must decide for itself whether to attempt to negotiate a contract. Your best asset in negotiations is a convincing case for improving health care access for the insurance company's membership.

If you choose to negotiate, it pays to be prepared. The more you know about how your LHJ is meeting the health care needs of a particular carrier the better. Document the number of members that your organization is seeing on a monthly or annual basis. Which services do these individuals and families typically seek? Be prepared to share some stories of how your organization is responding to the needs of insurance plan members.

Research the range of immunization and other benefits and reimbursement rates that insurers offer in your area. Obtain and review copies of contracts and fee schedules from other LHJs. Compare and contrast them. If particular language or terms contained in the proposed contract would be problematic for your agency, you may want to craft and propose language specific to your situation. This being said, customizing contracts takes time. Many LHJs and insurance companies alike have been unwilling to make



the time investment, but this is changing. Simple, straightforward modifications have the greatest chance of success.

Negotiations can help resolve some of the difficulties and barriers that the standard provider services agreements often present, such as liability insurance requirements and the duration of claim periods. During negotiations, an LHJ may request that provisions geared more towards private providers (such as having admitting privileges at local hospitals and a physician oncall) be removed. If your LHJ cannot comply with a provision of the standard agreement, consider an alternative approach. For example, it may be possible to comply by submitting a statement explaining how a particular situation would be managed by your agency.

If the proposed fee schedule is inadequate to cover costs, you may want to make a counter proposal based on a cost analysis. One tool available for this is the Vaccine Cost and Payment Comparison Spreadsheet (Appendix V and http://jeffersoncountypublichealth.org/index. php?publications-data-resources).

In the past, LHJs have successfully negotiated the following:

- Fee schedules including lab services
- Billing timelines
- Provisions that do not apply to LHJs
- Insurance requirements

If contract negotiations stall, your organization could pursue a business relationship built around a Memorandum of Understanding (MOU) as an alternative. For example, either you or the insurance company could ask, "Why don't we work under an MOU instead?"

Under the best of circumstances, it can take weeks to finalize the terms of a contract and get final approvals. Hang in there!

MOU (Memorandum of Understanding)

An insurance company may propose a written document called an MOU in lieu of, or in addition to, a Provider Services Agreement or other contract type. AN MOU can be a good option when the company is unwilling or unable to modify a standard contract to the degree necessary for the LHJ. A successful relationship developed through an MOU may evolve into an agency-specific contract at some point in the future.

Although MOUs can be written so as to be legally binding, an MOU is often less formal and won't necessarily be enforceable. Unless your legal advisor(s) indicate otherwise, don't expect to have any recourse if the terms of an MOU are no longer observed by the insurance company.

Credentialing

Credentialing is the process used to determine the current clinical competence of a provider and whether that person is eligible to participate in a particular insurance company network. Often, providers will be referred to as practitioners in insurance documents. Certain providers, usually doctors and ARNPs, will need to be credentialed individually by each private insurer. Once credentialing is complete, you're ready to pursue a contract with that insurer. Once a contract is in place with the LHJ, there is no need to reopen it in order to credential and add or remove providers.

An LHJ can initiate the credentialing process soon after the decision is made to pursue a contract with a particular carrier (i.e. to become a "preferred provider" or "in-network provider"). Consider identifying an administrator to serve as a liaison with insurance companies for the purpose of credentialing. Doctors and other practitioners may be too busy with clients to answer calls from insurers. They may lack the information to answer questions, for example, about the LHJ's DEA registration or liability coverage. Whoever is doing the credentialing at the LHJ should be the primary point of contact for the insurance company.

The newly credentialed practitioner will receive a welcome letter that confirms that credentialing has been completed successfully. At that point, be sure to inform the LHJ billing department that the provider has now been accepted within that particular plan's network.

Credentialing Application

The credentialing application process involves gathering and submitting information about the provider for the insurance carrier to evaluate. This information will include birth date, social security number, and address as well as education and work history.

Some insurance companies provide credentialing application form for the LHJ to complete. If not, download the current version of the "WA Practitioner Agreement" (WPA) through the Washington State Association Medical Staff Services (WAMSS) website at www.wamss. org under the heading "Tools." The WAMSS is a professional credentialing organization designed to serve licensed independent practitioners.

An administrator will need an hour or more to complete the forms for a given provider for the first time. Afterwards, essentially the same information will be used to complete forms for additional carriers so be sure to maintain a completed WPA form, or equivalent, on file for each provider.

Submit credentialing forms together with the required supporting documentation. Ninety days or more may elapse before you hear back from the insurance company. The administrator should be in communication with each practitioner throughout the credentialing process. Arrange with them to intercept any correspondence or forms related to credentialing that are addressed to the practitioner. You may be asked to supply additional information at any time.

Credentialing Databases

For LHJs intending to contract with multiple insurance companies, online databases streamline the credentialing process enormously. When credentialing information for providers is uploaded to one or more databases, the paperwork needed for this purpose is greatly



reduced. From then on, each time the LHJ approaches a new insurance company with membership in the particular online database, a much shorter paper application can be used for each provider.

OneHealthPort (http://www.onehealthport.com/ services/providersource live.php) is a database and statewide system for centralized collection, verification and distribution of provider data to be used for credentialing and privileging. In 2009, the Washington State Legislature passed SB 5346 to simplify health care administration. It called on the Office of the Insurance Commissioner (OIC) to appoint a private sector organization to lead implementation of the bill. The OIC designated the Washington Healthcare Forum and OneHealthPort to serve in this capacity.

Another credentialing database of interest to LHJs is managed by The Council for Affordable Quality Healthcare (CAQH) (www.caqh.org). CAQH is a nonprofit alliance of health plans and trade associations. There is no cost for LHJs to participate in the CAQH or *One*HealthPort databases.

Figure 3.1. An example of the first page of the Washington **Practitioner Application**

The complete application is available at www.wamss. org under the heading "Tools."

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- Keep an unsigned and undated copy of the application on file for future requests. When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ٠ Please sign and date pages 11 and 13.
- Please document any YES responses on the Attestation Question page.
- ٠ Identify the health care related organization(s) to which this application is being submitted in the space
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to: 1. INSTRUCTIONS This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application: (all are required for MDs, DOs; as applicable for other health practitioners). State Professional License(s) Face Sheet of Professional Liability Policy or Certificate **DEA Certificate** Curriculum Vitae (Not an acceptable substitute for completing the application.) ECFMG (if applicable) ** All sections must be completed in their entirety. ** 2. PRACTITIONER INFORMATION - Legal Name Required Last Name: (include suffix; Jr., Sr., III) Middle: Degree(s): List any other name(s) under which you have been known by reference, licensing and or educational institutions: Home Mailing Address: City: State: Zip Code: Pager Number: Cell Phone Number: E-Mail Address: Home Telephone Number: Birth Date: (mm/dd/yyyy) Birth Place (city, state, country): Citizenship: Social Security Number: Male Female Languages Fluently Spoken by Practitioner: Have you ever voluntarily opted-out of Medicare? Yes NPI: Medicare Number: (WA) Medicaid (DSHS) Number(s): L & I Number(s): Sub specialties primarily practicing: Specialty primarily practicing: Washington Practitioner Application - January 2011 PRACTITIONER NAME Page 1 of 13 Modification to the wording or format of the Washington Practitioner Application may invalidate the application



Credentialing information can be made available by permission to any other member insurance firm. Be aware that not all private health insurance companies are *One*HealthPort and/or CAQH members. Online credentialing databases require updates to provider information periodically. The credentialing entity will send email notifications to the credentialing administrator and also to the providers.

Periodically, insurance companies will require that providers re-credential. Re-credentialing can take the form of a comprehensive "provider profile packet," sent to the LHJ by the insurance carrier, or as a simple letter or email reminder asking for a limited amount of information. The frequency of re-credentialing will vary. Providers will be notified by insurance companies when recredentialing is necessary.

Take action on the request for re-credentialing as soon as possible because there will be a time limit for providing updated information. If a provider loses credentialing due to a late response, the LHJ may have to start the credentialing process from the beginning. Re-credentialing is unrelated to the process of license renewal and is on a different timeline.

Each individual practitioner is responsible for maintaining their licensure. The LHJ administration is responsible for maintaining the organization's liability insurance and its DEA license.

LHJs and Private Insurance Billing

If your LHJ already has experience billing Medicaid and/or Medicare, it may not be as difficult as you might expect to expand your billing system to include private plans. In addition, once you have the capacity and knowledge to bill private insurance for immunization, it may involve a relatively small effort to expand billing to cover additional health care services.

LHJs can always bill Usual and Customary Fees to private insurance with a completed CMS-1500 form. After the claim is filed electronically, it will usually be a couple of weeks until you hear back from the insurance company. Responses to paper claims require a month or longer. In the interim, you have the option of contacting the carrier to ask about the claim's status online or over the phone. Have the LHJ tax ID number or NPI number, provider name and date of service, and the patient's insurance policy number handy.

As you submit claims, you will learn more from "denials" than the successes. Think of denials as feedback, not final decisions. Thoroughly explore the reason for a claim's denial, make necessary corrections and resubmit for payment.

Confidentiality in Billing

There may be a desire on the part of the client to keep services such as HPV and HepB vaccinations confidential. Provide a form or questionnaire for clients to select their preferred payment method. These methods should include the option to pay full fee at the time of service or to, in other words, opt out of insurance billing (see Appendix T).

Bill Without a Contract

The billing relationship between an LHJ and a private insurer is governed by all applicable laws. It may be defined further through a contract, or any other written agreement, that the insurer and the LHJ choose to develop and enter into together. Such documents are not necessary in order for an LHJ to bill a private insurance company. However, non-contracted insurers still require providers to be credentialed, as appropriate, for their services to be eligible for reimbursement. In the absence of a contract, the LHJ can bill clients for balances left unpaid by the insurance plan. In other words, there is no requirement to write off unpaid balances where no contract exists.

Billing involves time and effort on the part of the LHJ, but private health insurance companies do not penalize organizations for submitting bills. While some of the bills you submit will likely be rejected, others will garner at least some payment. When private plans compensate for care from non-contracted providers, they may do so at the requested rate, at a reduced rate

compared to their contracted providers, or they may not pay at all. Some companies pay the same rate whether there is a contract in place or not.

Keep in mind that insurance plans and policies change from time to time. Non-contract companies that have rejected claims for immunization in the past won't necessarily reject them in the future. The reverse is also true. If you have been paid in the past, it's possible you could experience rejections down the road.

Non-contracted insurers typically send their payments directly to clients rather than the LHJ. The assumption is that the client paid for the service up front. Because an LHJ may occasionally receive reimbursement after the client has paid in full for a service, it's necessary to have a policy and process in place to immediately refund the client whenever this occurs.

The LHJ will receive a statement from the insurer indicating whether the LHJ or the client has received the reimbursement. If the LHJ provided the service, but didn't collect for it, the client won't necessarily forward the reimbursement that he or she receives. The LHJ may either bill the client or write off the expense consistent with its policies.

Information to Bill

In order to bill private insurance, you will need to gather information about the patient, the insurance plan and the service(s) provided to include in the electronic claim or on a CMS-1500 form (See Figure 2.1 on page 22).

Request the client's name and insurance membership card. Read and copy both sides of the card and scan it as appropriate. Ask for the name(s) of their insurance company(ies), policy number(s), group number(s), physical address and phone number. Verify that the information given by the patient and the information in the eligibility database are correct. By collecting detailed benefit information, you can help clients understand what to expect from the LHJ billing process.

From the insurance plan identification card or website, obtain the following:

- Patient's full name, ID numbers, birth date and the subscriber's name
- Billing contact phone number
- Appropriate claims address
- Coding information (CPT and ICD codes for the services provided)
- Your provider ID

The following information is usually available through the database or by calling the insurance company directly.

- 1. Deductible Amounts: For each coverage level, determine the deductible amounts that have been applied previously during the year as well as the remaining balance. Verify that any deductible applies to immunization services.
- 2. Co-payment Amounts: Determine the copayment amounts required for each type of service. Make sure these amounts reflect

whether the patient is in, or out of, their insurance company network. Collect the copay as required.

- 3. Out of Pocket (Stop Loss) Amounts: Determine the out of pocket (stop loss) amounts for each coverage level and service type for plans in and out of their network.
- 4. Co-Insurance Amounts and Percents: Get the detailed co-insurance amounts for each coverage level and service type.
- 5. Limitations: Determine the patient's medical coverage limitations.
- 6. Determine the Patient's Primary Care Provider: In some cases, the payer will give you information about the patient's primary care provider, including physician name and phone number.

More valuable information about the patient may be revealed by the database, according to the individual insurance plan.

If there are questions regarding the claim, the insurance plan will contact your LHJ using the standard agency information provided on the form. Usually carriers screen claims for format and then for patient eligibility.

Client Receipt for Reimbursement

If your organization decides not to bill private plans, there are some relatively simple ways to help your clients seek reimbursement on their own.

Unlike Medicaid, Medicare and Labor & Industries (L & I), most private insurance companies will reimburse patients directly. Some plans reimburse from receipts alone; many others also require a CMS-1500 or other appropriate claim form.

Access plan-specific patient claim forms at insurance carrier websites. Download and print the standard blank forms for patients as needed or print a number in advance for self service access in the client area. Before reprinting, check if the claim form has been updated.

Consider providing the following information to clients on the form or receipt:

- Agency Tax ID
- Procedure and Diagnosis Codes [CPT & ICD-9 (until October 1, 2013)]
- Itemized services with dates and amounts

It's important to provide some coaching on how to complete the form. You may want to provide clients with a billing department phone number so they can ask questions later.

Bill with a Contract

While contracted with a private insurance carrier, the billing process will remain largely unchanged. As long as the client has a single insurer, billing is fairly straight forward. You still need to gather client information, service codes and the appropriate NPI number(s) to complete the CMS-1500 claim form. However, the reimbursement rates will now be based on the contracted terms.

In the course of billing claims to contracted payers, you will learn about each of their billing requirements. For example, you might encounter a company that requires you to collect copayments for immunization.

Especially when a contract is in place, be sure to follow up on any denial codes you may receive on the EOB.

Co-insurance

A number of clients will have membership in two or more health insurance plans. If your LHJ is contracted with the secondary payer, you would still typically bill the primary insurer. Use the denial from the primary to bill the secondary plan. The LHJ is never in the roll of determining which insurance is primarily responsible for a claim.

When a client has Medicaid and/or Medicare as well as private insurance, Medicaid and/ or Medicare require that you bill the private insurance first. Medicaid is always the last payer.

Preauthorization

In some cases preauthorization is needed for immunization; other times it's not. The insurance company membership card may indicate whether or not a client can self refer. You may want to contact the insurance carrier or online database for information about preauthorization requirements or to determine if your agency can collect funds at the time of service.

Time Limits

Know time limitations for filing claims. Time limits can vary with the company. Private health insurance companies set their own time limits for filing. When contracting with health plans, you may want to negotiate billing time limitations so they fit well with your organization's business schedule.

Administration Fees for Pediatric **Combination Vaccines**

Combination vaccines are those vaccines that contain multiple vaccine components. Some combination vaccines such as MMR (mumps, measles and rubella) or DTaP (Diphtheria, tetanus and acellular pertussis) have been around for a long time. Other combination vaccines are relatively new, such as Pentacel, a combination vaccine including DTaP, Hib, and IPV or polio vaccine components.

Private insurance allows providers to claim multiple administration fees when they provide education and counseling with a combination vaccine. The administration fee can be applied to each antigen in the vaccine. For example, if MMR vaccine is given, and education and counseling are provided for the mumps, measles and rubella components, an administration fee can be applied for each antigen. Private insurance can be billed the multiple administration fees for public- or private-purchase vaccine given to their members. All providers (including LHJs) should bill their Usual & Customary rate for each administration code.



The education and counseling codes can also be used for non-Medicaid Vaccines for Children (VFC) eligible patients-children less than 19 years of age who are uninsured, underinsured, or Native American or Alaskan Native. However, the total of all the administration fees for a specific combination vaccine cannot exceed the federal VFC cap set for WA Stateat \$15.60 per dose.

No provider can currently bill using multiple administration fees for combination vaccines administered to a child less than 19 years of age enrolled in the Washington State Medicaid Program. As per the Medicaid State Plan, they only reimburse \$5.96 per vaccine dose for these children.

The Current Procedural Terminology (CPT ®) codes 90460 and 90461 replaced codes 90465-90468 on January 1, 2011. Code 90460 is reported once for counseling associated with the first vaccine component. Code 90461 is additionally reported for the counseling associated with each additional component of the combination vaccine. The American Academy of Pediatrics provides guidance on pediatric immunization administrative codes through its website at http:// practice.aap.org/content.aspx?aid=2980.

Chapter 4

Billing Medicare





4. Billing Medicare

Your local health jurisdiction (LHJ) will likely provide immunization services to Medicare beneficiaries. This section provides information to help you navigate the enrollment and billing processes for Medicare and, to a lesser degree, Railroad Medicare. More complete information for new Medicare billers can be found at www. noridianmedicare.com/p-medb/welcome/index. html#cms-links. It includes links to the Medicare Learning Network® as well as a CMS-1500 claim form tutorial.

What is Medicare?

Medicare is the nation's largest health insurance program. It was established by the U.S. Congress in 1965. Medicare provides care for people over 65 and people of all ages with certain disabilities. Doctor's services, outpatient care, and other medical services, such as immunization, are covered under Part B of the program. Medicare preventive services include vaccinations against invasive pneumococcal disease, hepatitis B, and influenza. Medicare and Railroad Medicare are both federal insurance plans, but billing enrollment for Medicare and Railroad Medicare are accomplished through two separate processes. Reimbursement rates for immunization are the same for Medicare and Railroad Medicare.

Local health jurisdictions must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries. LHJs must enroll even if immunizations are the only service they will provide to beneficiaries.

Medicare and Vaccines

Any individual or entity meeting State licensure requirements may qualify to bill Medicare for furnishing and administering the influenza and/or pneumococcal vaccines to Medicare beneficiaries enrolled under Part B.

Medicare Part B pays for pneumococcal vaccines, influenza virus vaccines, and their administration without coinsurance or deductibles. It is inappropriate to require a client to pay for the vaccination up front and to file their own claim for reimbursement. All Medicare providers are required to file claims on behalf of the client per §1848(g)(4)(A) of the Social Security Act.

Medicare providers of immunization services can choose from a variety of billing methods depending on their needs. Regardless of the method you choose, be sure to determine the current time limitation for filing claims.

Pneumococcal Vaccine

Typically, the pneumococcal vaccine is administered once in a lifetime. Medicare began paying for pneumococcal vaccine in 1981. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received a pneumococcal vaccine within the last five years or are revaccinated because they are unsure of their vaccination status.

Since the pneumococcal vaccine benefit does not require any client coinsurance or deductible, a Medicare client has a right to receive this benefit without incurring any out-of-pocket expense. Medicare does not pay solely for counseling and education for pneumococcal vaccinations.

Influenza Virus Vaccine

Coverage of the influenza virus vaccine and its administration was added to the Medicare Program on May 1, 1993. Typically, one influenza vaccination is allowable per influenza virus season. Medicare may provide coverage for more than one influenza vaccination per flu season if it is reasonable and medically necessary.

Hepatitis B Vaccine

LHJs that operate as clinics offering a range of medical and/or immunization services may provide hepatitis B vaccine to Medicare beneficiaries when its administration is ordered by a doctor of medicine or osteopathy. Part B of Medicare covers the hepatitis B vaccine and its

administration. Part B deductible and coinsurance do apply for hepatitis B vaccine.

Consult the Medicare Benefit Policy Manual (currently Pub. 100-02, chapter 15, section 50.4.4.2) for coverage requirements for vaccines.

Mandatory Assignment

The Benefits Improvement and Protection Act of 2000 mandates all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of influenza virus and pneumococcal vaccines must accept assignment for the vaccine.

Online Assistance for LHJs and Medicare Beneficiaries

Online assistance for Medicare enrollment for LHJs is maintained by the Centers for Medicare & Medicaid Services (CMS) (www.cms.gov) and independent contractors known as fee-forservice contractors. Noridian Administrative Services, LLC (www.noridianmedicare.com) is the Medicare fee-for-service contractor serving Washington when this guide was published and is responsible for processing enrollment materials. Fee-for-service contractor information is available to download from the CMS Medicare Provider-Supplier Enrollment website (www.cms.gov/MedicareProviderSupEnroll). Medicare information for beneficiaries and their families can be found at http://Medicare.gov.

i <u>www.cms.gov/manuals/downloads/</u> <u>clm104c18.pdf pg. 21</u>

Enroll in Medicare on Paper or Electronically

The Medicare enrollment application for LHJs is Form CMS 855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers).

Complete the online application through the CMS Provider Enrollment, Chain and Ownership System (PECOS) or download and print a paper copy of Form CMS 855B at the Medicare Provider-Supplier Enrollment website: www.cms.gov/ MedicareProviderSupEnroll.

Enroll in Railroad Medicare through Palmetto GBA Medicare at www.palmettogba.com/palmetto/ providers.nsf/DocsCatHome/Railroad%20 Medicare. In "Top Links", click on Provider Enrollment. You will still need to enroll with the local carrier (Noridian www.noridianmedicare. com), and if you intend to bill electronically, request a Railroad Medicare Provider Transaction Access Number (PTAN) through the Railroad Medicare Provider Enrollment materials located on the Palmetto GBA Medicare Provider Enrollment webpage.

The Railroad Medicare Roster Billing Guide for Influenza and Pneumonia Immunization to Medicare Part B is available at www.palmettogba. com/Palmetto/Providers.nsf/files/PalmettoGBA_ Influenza and Pneumococcal Roster Billing Packet.pdf/\$FIle/PalmettoGBA Influenza and Pneumococcal Roster Billing Packet.pdf.

Since most enrollment forms are updated from time to time, be sure to identify and submit the current versions.

Provider Enrollment, Chain and Ownership System (PECOS)

Enrollment through Internet-based PECOS has advantages over the paper-based enrollment process. Fewer staff hours are needed to apply online because PECOS is a menu driven process that tailors questions to the applicant. It ensures that only current versions of forms are submitted. Plus, PECOS makes it easier to check and update information for accuracy over time.

Before beginning with PECOS, make sure you have Internet Explorer version 5.5 or higher and the most recent version of Adobe Acrobat Reader. A PECOS enrollment example is available online: www.cms.gov/MedicareProviderSupEnroll/ downloads/PECOSWebScreenExample.pdf.

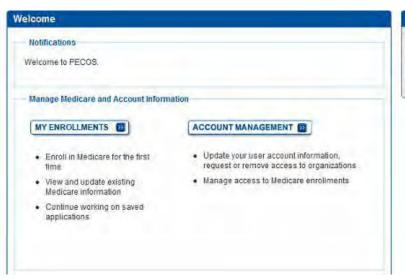




Figure 4.1. PECOS Welcome Page

Register to Use PECOS

Registered users of PECOS may view or update existing enrollment and user information, view the status of applications submitted to Medicare through the PECOS website, and voluntarily withdraw enrollment in Medicare.

In order to utilize PECOS, the local health organization's Authorized User (AU) must register in the PECOS Identification and Authentication System (PECOS I&A) when accessing PECOS for the first time. The AU creates a user ID and password linked to the organization's National Provider Identifier (NPI). After the CMS External User Services (EUS) Help Desk authenticates the AU, that person will be able to manage access to the account for other individuals and themselves.

National Provider Identifier (NPI)

CMS requires LHJs to obtain a National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare. If you do not have an NPI, please contact the NPI Enumerator at https://nppes.cms.hhs.gov or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

Additional Application Forms

Two other forms are routinely submitted with an enrollment application:

1. The Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS 588) is mandatory. The CMS-588 must be signed by the authorized official that signs the Medicare enrollment application.

2. The Medicare Participating Physician or Supplier Agreement (Form CMS 460) is optional but increases the amount of Medicare reimbursement to an LHJ by 5 percent.

Noridian Administrative Services LLC (NAS) offers an online "Provider Interactive Enrollment Interview" to help identify the forms and documentation needed to enroll. Link to the Noridian Enrollment website for Medicare Part B at www.noridianmedicare.com/p-medb/enroll.

Mailing Medicare Enrollment Materials

Mail the completed paper application forms and any supporting documentation to the Medicare fee-for-service contractor (i.e. Noridian), not CMS. Regardless of whether the application is completed on paper or online, the provider must mail a signed certification statement to the Medicare contractor. The date that the statement is received affects the billing effective date for providers. The current NAS address for provider enrollment is on the "Contacts" page of the NAS website.

If your LHJ is already enrolled in Medicare, but has not submitted a CMS-855B since 2003, you are required to submit a complete application. Providers should follow the instructions for completing an initial enrollment application.

Refer to the Medicare Claims Processing Manual, Chapter 18, Sections 10-10.5 at www.cms.hhs. gov/manuals/downloads/clm104c18.pdf on the CMS website for more information on billing requirements.

Type of Medicare Supplier

PECOS and Form CMS-855B ask you to properly identify your LHJ supplier type. Most LHJs fall into the category of "Mass Immunizer" or "Other."

If your LHJ provides Part B services in addition to the influenza virus and/or pneumococcal vaccinations and wishes to bill for these other services, identify your clinic or organization as "Other" and write in the words "Group Practice." If your LHJ will bill Medicare only for mass immunization programs, enroll as a Mass Immunizer. Call Noridian at 1-888-608-8816 if you have questions about Supplier Type or any other aspect of enrollment.

Roster Billing (influenza virus and/or pneumococcal vaccinations only)

CMS initiated a streamlined billing process in 1993 known as roster billing. Paper claims for roster billing of Medicare-covered vaccinations are exempt from the HIPAA electronic billing requirement under a ruling published August 15, 2003. The process was developed to enable LHJs and other providers to submit health care claims to Medicare contractors for large groups of individuals for influenza virus and/

i To reference the ruling, go to http://edocket. access.gpo.gov/2003/pdf/03-20955.pdf

SECTION 2: IDENTIFYING INFORMATION A. Type of Supplier Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application. Your organization must meet all Federal and State requirements for the type of supplier checked below. TYPE OF SUPPLIER: (Check one only) ☐ Mass Immunization (Roster Biller Only) ☐ Ambulance Service Supplier ☐ Ambulatory Surgical Center Clinic ☐ Pharmacy Group Practice ☐ Physical/Occupational Therapy Group in ☐ Hospital Department(s) Private Practice ☐ Independent Clinical Laboratory ☐ Portable X-ray Supplier ☐ Independent Diagnostic Testing Facility ☐ Radiation Therapy Center ☐ Intensive Cardiac Rehabilitation □ Other (Specify): ☐ Mammography Center **B. Supplier Identification Information** 1. BUSINESS INFORMATION Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service Tax Identification Number Other Name Type of Other Name ☐ Former Legal Business Name ☐ Doing Business As Name Other (Specify): Identify how your business is registered with the IRS. (NOTE: If your business is a Federal and/or State government provider or supplier, indicate "Non-Profit" below.) ☐ Proprietary ☐ Non-Profit NOTE: If a checkbox indicating Proprietary or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary," Identify the type of organizational structure of this provider/supplier (Check one) ☐ Corporation ☐ Limited Liability Company ☐ Partnership ☐ Sole Proprietor ☐ Other (Specify): Incorporation Date Immiddlyyyy) (if applicable) State Where Incorporated (if applicable) Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)? ☐ Yes ☐ No CM5-8558 (07/11)

Figure 4.2. Excerpt from Form CMS 855B or pneumococcal vaccinations. Medicare has not developed roster billing for hepatitis B vaccinations.

Since the pneumococcal vaccine benefit does not require any client coinsurance or deductible, a Medicare client has a right to receive this benefit without incurring any out-of-pocket expense. Medicare does not pay solely for counseling and education for pneumococcal vaccinations.

Roster billing can be done electronically or on paper. It uses a simplified CMS-1500 claim form or electronic equivalent and requires LHJs to accept assignment on both vaccines and their administration. The information from the client roster list and the abbreviated CMS-1500 form is used by Medicare to create individual claims for Medicare to process.

LHJs submitting Part B claims are not required to immunize at least five beneficiaries on the same date in order to qualify for roster billing. However, the rosters should not be used for single patient bills, and the date of service for each vaccination administered must be entered.

LHJs that do not mass immunize should continue to bill for the influenza and pneumococcal vaccine using the normal billing method, i.e., submission of a CMS-1500 form or electronic billing for each client. The agency will still be required to accept assignment on vaccine.

Using the CMS-1500 Claim Form for Roster Billing

Roster billers must use CMS-1500 claim forms that are preprinted to include standardized information particular to the LHJ. A single copy of the completed CMS-1500 form is then attached to each completed roster form.

Medicare providers are responsible for filling out required items on the claims forms with correct information obtained from the client. You can find Medicare CMS-1500 completion and coding instructions, as well as the print specifications in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).

The roster must have the client's name (first and last), address, gender, Medicare Health Insurance Claim (HIC) number, date of birth and the client's signature. The client's name and Medicare HIC number must be submitted as it appears on the Medicare card. This information must be legible in order for NAS to process the roster correctly. Illegible information may not be processed correctly and will result in incorrect or delayed reimbursement.

From the provider, a stamped "signature on file" statement is acceptable on a roster claim to qualify as an actual signature. The provider must already have a signed authorization on file to bill Medicare for services rendered. This stamp must be in box 12 of the CM-1500 claim form or on each line of the roster. If all the requirements

i www.cms.gov/manuals/downloads/clm104c26.pdf

are not met, NAS will return the claim without processing. A single stamp on the top or bottom of the roster is not acceptable. Quotation marks used to indicate that the statement should be copied from the line above are not acceptable; this stamp must be on each line of the roster.

The blocks listed in **Table 4a**i on the following page can be preprinted on a modified Form CMS-1500 for entities using roster billing for influenza virus vaccine, pneumococcal, and/or administration claims submitted to Medicare contractors.

i Source: Noridian Administrative Services LLC Flu Book – Influenza and Pneumococcal Vaccinations Medicare Part B Roster Billing Guide December 2010 www.noridianmedicare.com/p-medb/forms/ docs/influenza_vaccine_roster_brochure.pdf



Table 4a.: Information to include in pre-printed CMS-1500 Claim forms

CMS 1500	Influenza	Pneumococcal			
Item 1	"X" in the Medicare box.				
Item 2	"SEE ATTACHED ROSTER" must be entered.				
Item 11	"NONE" must be entered. If this phrase isn't entered as shown here, the claim(s) will be returned without processing.				
Item 12	A "Signature on File" must be either in item 12 OR on every line of the roster. If requirements are not met, the claim will be returned without processing.				
Item 21	"V04.81" DO NOT USE THE LETTER O.	"V03.82" DO NOT USE THE LETTER O.			
Item 24	The Date of Service (one per CMS-1500 Claim Form) should be entered in 6 or 8-digit format (MM/DD/YY or MM/DD/CCYY). Do not submit alpha dates (E.g. November 2, 2011). Rosters with alphabetical dates will be returned without processing.				
Item 24B	"60" (Mass Immunization Clinic) Any other place of service entered will cause delays in processing.				
Item 24D	Only one CPT/HCPCS code is to be submitted per line. If no procedure codes are submitted, the claim will be returned without processing.				
	"90658" (vaccine) only valid until December 31, 2010. New Influenza Codes effective October 1, 2010 (replace 90658) per CR7234 Q2035 Afluria vacc, 3 yrs &>, im Q2036 Flulaval vacc, 3 yrs &>, im Q2037 Fluvirin vacc, 3 yrs &>, im Q2038 Fluzone vacc, 3 yrs &>, im Q2039 NOS flu vacc, 3 yrs&>, im "G0008" (administration)	"90732" (vaccine) and "G0009" (administration)			
Item 24E	Link "1" to reference the appropriate diagnosis code in Item 21. Do not submit the actual diagnosis code.				
Item 24F	The charge for one service to each beneficiary must be entered. The amount should be entered with dollars and cents. Hyphens should not be used to indicate cents. IF the entity is not charging for the vaccine or its administration, it should enter 0.00 on the appropriate line for that item.				
Item 27	"X" in the YES box.				
Item 28	The total charge for one service to each beneficiary must be entered. The amount should be entered with dollars and cents. Hyphens should not be used to indicate cents.				
Item 29	Enter the digit "0" or leave blank.				
Item 31	Submit signature and the date the form was signed. If requirements are not met, the claim will be returned without processing.				
Item 33	Provider name and address.				
Item 33a	Submit NPI number in lower left corner of Item 33.				
Item 33b	Leave Blank.				

Table 4b. Helpful Hints Checklist for CMS-1500 Claim Form

Use preprinted red drop-out ink
If claim corrections are needed, submit a new CMS-1500 claim form (not a corrected claim)
Submit rosters of no more than 20 beneficiaries per CMS-1500 form
The CMS-1500 form must be submitted with a roster
Item 11: Never left blank (enter NONE)
Item 12: Client signature must be filled in or signature on the roster
Item 19: Include donated vaccine, reflect CPT in narrative
Item 21: Diagnosis
Item 24A: Make sure the claim date of service matches roster date (alphanumeric not acceptable)
Item 24D: Submit appropriate CPT codes
Item 24J: Submit individual NPI in the detail line (if applicable)
Item 27: Must accept assignment
Item 31: Include both the provider signature and the date
Item 33A: Roster NPIs (10 digit numeric) must match CMS-1500 form NPIs

You can find Medicare CMS-1500 completion and coding instructions, as well as print specifications in Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the Medicare Claims Processing Manual (Pub.100-04)ⁱ or contact NAS." Additional information on the CMS-1500 form can be found at on the CMS website."

Bill Flu and Pneumococcal Vaccines Separately

Influenza and pneumococcal vaccine roster billing must be handled separately. For each type of vaccine and each date of service, submit separate claim forms accompanied by separate roster bills.

ElectronicBillingEDITrans/16 1500.asp

i www.cms.gov/manuals/downloads/clm104c26.pdf

ii www.noridianmedicare.com

iii www.cms.hhs.gov/

Figure 4.3. CMS-1500 Claim Form Influenza (FLU) Template i

CMS-1500 CLAIM FORM INFLUENZA (FLU) TEMPLATE 1500 **HEALTH INSURANCE CLAIM FORM** See Attached Roster NONE 80 YES (12) 24B (24E) 24F 60 90658 SS CC G0008 60 55 cc 3 28 20 BALANCE DUE 0.00 = \$5 cc 1 (33) 31 (33a

Administrative Services LLC Flu Book - Influenza and Pneumococcal Vaccinations Medicare Part **B** Roster Billing **Guide December** 2010 www. noridianmedicare. com/p-medb/ forms/docs/ influenza_vaccine_ roster_brochure.pdf

i Source: Noridian

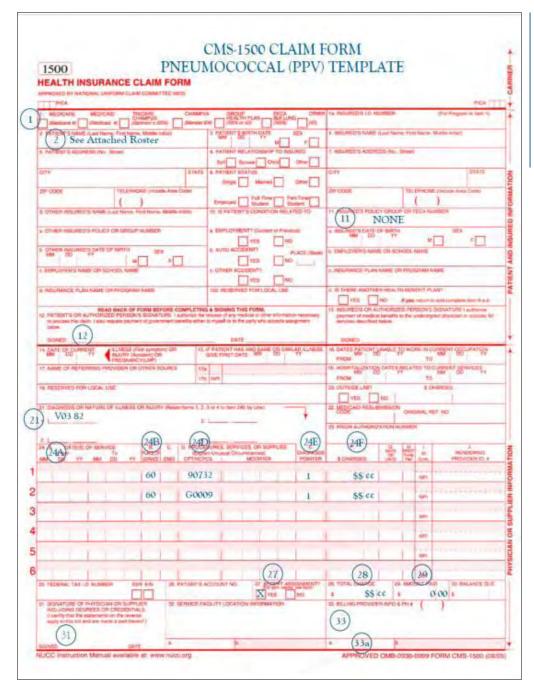


Figure 4.4. CMS-1500 Claim Form **Pneumococcal** (PPV) Templatei

i Source: Noridian Administrative Services LLC Flu Book - Influenza and Pneumococcal Vaccinations Medicare Part B Roster Billing **Guide December** 2010 <u>www.</u> noridianmedicare. com/p-medb/ forms/docs/ influenza_vaccine_ roster_brochure.pdf

Roster Templates

Rosters are developed by the LHJ with information particular to the organization. Rosters should be submitted with legible information. If the information on the roster is not typed, then the

information should be printed clearly; illegible information may cause incorrect payments, denials, or delays in processing. An acceptable roster form must include the following information:

Table 4c.: Roster Template Instructions

NOTE: Roster forms containing missing or invalid beneficiary information will be returned without processing.

Corresponding Number	Influenza (FLU) Vaccine Roster Form	Pneumococcal (PPV) Vaccine Roster Form
1. Provider Name	Name of the provider submitting the flu roster.	
2. Date of Service	MUST match the date submitted in Item 24A of the CMS-1500 Claim Form. If no date is submitted in item 24A, different dates of services may be submitted on the rosters. Alpha dates are not acceptable.	
3. NPI	MUST match the NPI submitted on the CMS-1500 Claim Form. If the NPI does not match EXACTLY in ALL submitted areas, the claim will be returned without processing. The valid format for a NPI number is 10 numerics beginning with a 1, 2, 3, or 4. If an invalid format is submitted, the claim will be returned without processing.	
4. Beneficiary's Health Insurance Card # (HIC)	HIC numbers are most commonly in the	ber exactly as it appears on the Medicare card. format of nine numbers followed by one alpha umn for the alpha character; doing so would would be returned without processing.
5. Date of Birth	SUBMIT the beneficiary's date of birth (M	/IM/DD/CCYY)
6. Patient's Sex	CHECK the appropriate box.	
7. First Name	SUBMIT the beneficiary's first name exac	tly as it appears on the Medicare card.
8. Last Name	SUBMIT the beneficiary's last name exact	tly as it appears on the Medicare card.
9. Middle Initial	SUBMIT the beneficiary's middle initial.	
10. Patient's Street Address	SUBMIT the beneficiary's street address.	
10a. Patient's City	SUBMIT the beneficiary's city.	
10b. Patient's State	SUBMIT the beneficiary's state.	
10c. Patient's Zip	SUBMIT the beneficiary's zip.	
11. Patient Signature		e on File statement is acceptable as long as it is n item 12 on the CMS-1500 (08-05) Claim Form.
12. Control # for Contractor	For use by the Contractor only.	

In addition the following information must be on the **PPV** Roster:

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

- Rely on patients' 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 that they have been vaccinated within the past 5 years, do not revaccinate.

Table 4d. Helpful Hints Checklist for Roster Form 2010-2011

(Influenza or Pneumococcal (PPV) Vaccine Roster)

Use correct NAS roster (one of two) - Influenza or pneumococcal
Roster must be on white paper (cannot process colored paper)
Non Medicare client - use a thick black marker to cross off name(s)
Use only black or blue ink (some ink colors not recognized by OCR scanner)
Include enough spacing between the lines so information is read correctly and legibly
Submit roster with a CMS-1500 claim form
Confirm client Medicare Health Insurance Claim (HIC) # on roster
Include HIC # EXACTLY as it appears on the Medicare card
HIC # is nine numbers followed by one or two alpha
Four or more invalid/missing HIC #s on roster will cause rejection
Date of Birth (DOB) must be reflected on the roster
Each client address (with city, state and zip) must be reflected on the roster
The date of service should be submitted in one of two places: 1) Item 24A on the CMS-1500 form, OR 2) at the top of the roster form in the area designated as "Date of Service." If dates are submitted in both of these places the dates must match;
Gender box must be marked
The client's signature may be indicated in one of two places. A signature on file statement may be submitted in Item 12 on the CMS-1500 form or the actual patient's signature or a signature on file statement may be submitted on each line of the roster. A single stamp on the top or bottom of the roster is NOT acceptable. Quotes or any other "shortcut" used to indicate that the statement should be copied from the line above is NOT acceptable. The actual signature or the signature indicator must be legible.
Medicare providers may not list other covered services with the influenza virus and/or pneumococcal vaccine and administration on the modified Form CMS-1500 form. Other covered services are subject to more comprehensive data requirements that the roster billing process is not designed to accommodate. Providers must bill other services using normal Medicare Part B claims filing procedures and forms.

Figure 4.5. Influenza (FLU) Vaccine Roster Form i

i Source: Noridian Administrative Services LLC Flu Book – Influenza and Pneumococcal Vaccinations Medicare Part B Roster Billing Guide December 2010 <u>www.</u> noridianmedicare. com/p-medb/ forms/docs/ influenza_vaccine_ roster_brochure.pdf

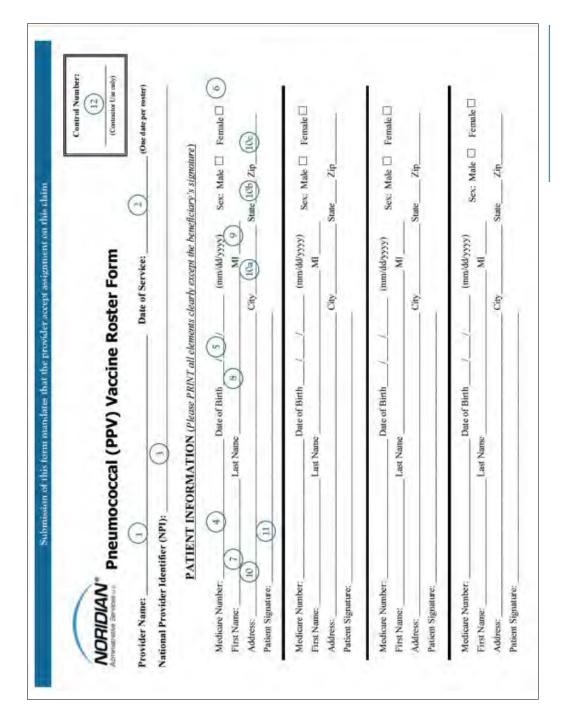


Figure 4.6.
Pneumococcal
(PPV) Vaccine
Roster Formⁱ

i Source: Noridian
Administrative
Services LLC Flu
Book – Influenza
and Pneumococcal
Vaccinations
Medicare Part
B Roster Billing
Guide December
2010 www.
noridianmedicare.
com/p-medb/
forms/docs/
influenza_vaccine_
roster_brochure.pdf

Electronic Billing

CMS generally requires electronic submission of billing claims through the Medicare Electronic Data Interchange (EDI) and submission of electronic media claims (EMC). EDI allows for electronic transmission of roster claims as well. Access the CMS Electronic Billing and EDI Transactions website at www.cms.gov/ElectronicBillingEDITrans/01_Overview.asp#TopOfPage.

LHJs should enroll in EDI whether they intend to submit claims themselves or engage a billing service or clearinghouse. In the enrollment agreement, the provider accepts responsibility for safeguarding of client data. The LHJ, in turn, requires any billing service or clearinghouse that they may engage to assist with transmission of client data to sign an agreement to meet the same security and privacy requirements as required by CMS and HIPAA. As part of their EDI Enrollment, each provider must submit a written notice to their Medicare contractor (i.e. NAS) specifying which transactions a billing service or clearinghouse is authorized to submit or receive on behalf of the provider, and must notify that same Medicare contractor whenever there is a change.

Providers need to obtain appropriate software and secure transmission capability to transmit claims to the EDI bulletin system directly or to a billing vendor. LHJs can purchase software from a vendor, contract with a billing service or clearinghouse for software or programming



support, or use HIPAA compliant free billing software that is supplied by Medicare carriers such as NAS. Medicare contractors are allowed to collect a fee to recoup their costs (currently up to \$25) if a provider requests a Medicare contractor to mail an initial disk or update disks for this free software. In Washington, contact NAS for additional information on EDI, software vendors, billing services and clearinghouses at www.edissweb.com/cgp/index.html.

How Electronic Claims Submission Works

The claim is electronically transmitted in data "packets" from the provider's computer system to the Medicare contractor's. The Medicare contractor then performs a series of edits. The

initial edits are to determine if the claims in a batch meet the basic requirements of the HIPAA standard. If errors are detected at this level, the entire batch of claims would be rejected for correction and resubmission.

Claims that pass these initial edits, commonly known as front-end edits or pre-edits, are then edited against implementation guide requirements in those HIPAA claim standards. If errors are detected at this level, only the individual claims that included those errors would be rejected for correction and resubmission. Once the first two levels of edits are passed, each claim is edited for compliance with Medicare coverage and payment policy requirements. Edits at this level could result in rejection of individual claims for correction, or denial of individual claims. In each case, the submitter of the batch or of the individual claims is sent a response that indicates the error to be corrected or the reason for the denial. After successful transmission, an acknowledgement report is generated and is either transmitted back to the submitter of each claim, or placed in an electronic mailbox for downloading by that submitter.

For more information contact Noridian or refer to the Medicare Claims Processing Manual (Pub.100-04), Chapter 24.

NAS System or Clearinghouse?

Cost savings is the main advantage to an LHJ of submitting Medicare claims directly to EDI using the NAS system and software. The disadvantage of doing this is having to meet the testing or certification requirements of each payer which can take weeks or longer. Additionally, if your LHJ will need to submit claims to multiple payers, it will require billing staff to understand multiple transmission methods, error codes, claim status reports, file names and file types. It may be necessary to purchase additional software components to meet the separate requirements of each insurer.

Eligibility Verification for Medicare

A person's eligibility for Medicare Part B coverage is indicated on their Medicare card. The Medicare card clearly displays Part A and/or Part B. The Social Security Administration can be reached by phone at 1-800-772-1213 to provide detailed information related to Medicare eligibility and enrollment. Prospective Medicare clients can also visit www.ssa.gov. LHJs will need to verify eligibility by asking to view the card or by registering with a free service, such as Cortex EDI Electronic Biller (www.cortexedi.com) in combination with information gathered from the client to help confirm eligibility.

i www.cms.gov/manuals/downloads/clm104c24.pdf

HCPCS Codes

Healthcare Common Procedure Coding System numbers (HCPCS Codes) are codes used to represent healthcare services by Medicare and monitored by CMS, the Centers for Medicare and Medicaid Services. They are based on the CPT Codes (Current Procedural Technology codes) developed and copyrighted by the American Medical Association.

The source for the information contained in the following tables is the 2010-2011 Immunizers' Question & Answer Guide to Medicare Part B & Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations.

i www.cms.gov/AdultImmunization/Down loads/20102011ImmunizersGuide.pdf

Table 4e. CPT/HCPCS Codes and Descriptions for Influenza Virus Vaccinations

CPT/HCPCS Code	Description
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90660	Influenza vaccine, live, for intranasal use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increase antigen content, for intramuscular use. (High Dose)
G0008	Administration of influenza virus vaccine

Table 4f. Diagnosis Codes and Descriptions for Influenza Virus Vaccinations

CPT/HCPCS Code	Description
V04.8	Influenza vaccination with dates of service prior to 10/01/2003
V04.81	Influenza vaccination with dates of service 10/01/2003 and later
V06.6	Influenza and pneumococcal (Effective October 1, 2006, providers must report diagnosis code V06.6 on claims when the purpose of the visit was to receive both vaccinations during the same visit)

Table 4g. CPT/HCPCS Codes and Descriptions for Pneumococcal Vaccinations

CPT/HCPCS Code	Description
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine when no physician fee schedule service on the same day

Table 4h. Diagnosis Codes and Descriptions for Pneumococcal Vaccinations

CPT/HCPCS Code	Description
V03.82	Pneumococcal Vaccination
V06.6	Pneumococcal and Influenza (Effective October 1, 2006, providers must report diagnosis code V06.6 on claims when the purpose of the visit was to receive both vaccinations during the same visit)

Table 4i. HCPCS Codes and Descriptions for Multi-Dose Pneumococcal Vaccinations

CPT/HCPCS Code	Description
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Please note: The HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) replace the CPT code 90658 previously used for Medicare payment. It is very important to distinguish between the various CPT and HCPCS codes which describe the different formulations of the influenza vaccines (i.e. pediatric dose, regular dose, high dose, preservative free, etc.). As a reference, the quarterly Part B drug pricing files includes a set of National Drug Code (NDC) to HCPCS crosswalks available online at www.cms.gov/McrPartBDrugAvgSalesPrice on the Centers for Medicare & Medicaid Services (CMS) website.

G Codes

G Codes are used to designate the administration of a vaccine.

For example, when billing for influenza virus vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the CMS-1500 claim form. When billing for the influenza virus vaccine only, billers should list only HCPCS code 90658 in block 24D of the CMS-1500 form. The same applies for pneumococcal and hepatitis B billing using pneumococcal and hepatitis B HCPCS codes.

When a vaccine and the administration of the vaccine are furnished by two different entities, the entities should submit separate claims.

Q Codes

Q Codes are used to designate multi-dose flu vaccines.

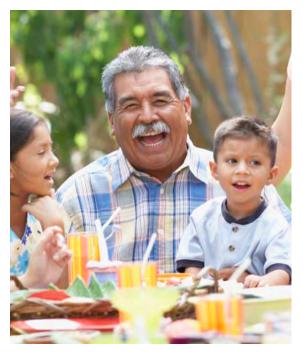
Providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered, even where the vaccine involves multiple doses.

Advanced Client Notice (ABN)

An Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is a standardized notice that the LHJ designee must give to a Medicare beneficiary before providing certain items or services, including Medicare Part B (outpatient) services. The ABN must be issued when the health care provider believes that Medicare may not pay for an item or service that Medicare usually covers because it is not considered medically reasonable and necessary for this patient in this particular instance.

ABNs are only provided to beneficiaries enrolled in Original (Fee-For-Service) Medicare. The ABN allows the client to make an informed decision about whether to receive services and accept financial responsibility for those services if Medicare does not pay. The ABN serves as proof that the beneficiary had knowledge prior to receiving the service that Medicare might not pay. If the LHJ does not deliver a valid ABN to the beneficiary when required by statute, the client cannot be billed for the service and the provider may be held financially liable.

The ABN also serves as an optional notice that LHJs may use to forewarn beneficiaries of their financial liability prior to providing care that Medicare never covers. ABN issuance is not required in order to bill a beneficiary for an item or service that is not a Medicare benefit and thus, never covered.



Look for the current version of the approved notice in the CMS Manual System Pub 100-04 Medicare Claims Processing (www.cms.gov/Transmittals). A CMS booklet with more information on the ABN is available at www.cms.gov/MLNProducts/ downloads/ABN Booklet ICN006266.pdf.

By signing an Advanced Client Notice, a client agrees to be responsible for items or services outof-pocket or through any insurance other than Medicare that the client may have. The LHJ may bill and collect funds from the client immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law.

Figure 4.7. Example of an Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE; If Medicare doesn't pledicare does not pay for eve	pay for D. below, you may have to rything, even some care that you or your health car. We expect Medicare may not pay for the D.	pay.
D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
TOTAL OF THE BULL		
Ask us any questions Choose an option belo Note: If you choose 0 that you might !	ou can make an informed decision about your can that you may have after you finish reading, by about whether to receive the D . Option 1 or 2, we may help you to use any other in have, but Medicare cannot require us to do this.	listed above.
Read this notice, so you will refund any portions: Choose an option below that you might to the control of the	ou can make an informed decision about your can that you may have after you finish reading, by about whether to receive the D . Option 1 or 2, we may help you to use any other in	paid now, but I me on a Medicar posible for N. If Medicare bles care. You may tare is not billed the this choice I
Read this notice, so ye Ask us any questions Choose an option belo Note: If you choose C that you might to GOPTIONS: Check only OPTION 1. I want the D. also want Medicare billed for payment, but I can appeal to does pay, you will refund any OPTION 2. I want the D ask to be paid now as I am re OPTION 3. I don't want the OPTION 3. I don't want the mot responsible for payme H. Additional Information: his notice gives our opinion is notice or Medicare billing.	cou can make an informed decision about your can that you may have after you finish reading. On about whether to receive the D. Option 1 or 2, we may help you to use any other in have, but Medicare cannot require us to do this. Isted above. You may ask to be plan official decision on payment, which is sent to rederstand that if Medicare doesn't pay, I am respondent that if Medicare doesn't pay, I am respondent to the payments I made to you, less co-pays or deduction. Isted above, but do not bill Medicare D. Isted above. I understand will be possible for payment. I cannot appeal if Medicare D. Isted above. I understand will be possible for payment. I cannot appeal if Medicare D. Isted above. I understand will be possible for payment. I cannot appeal if Medicare D. Isted above. I understand will be provided to the payment. I cannot appeal if Medicare D. Isted above. I understand will be payment.	paid now, but I me on a Medicare horsible for N. If Medicare bles care. You may hare is not billed the his choice I ald pay.



If Medicare ultimately denies payment of the related claim, the LHJ retains the funds collected from the client. If Medicare finds the LHJ liable or subsequently pays all or part of the claim for items or services previously paid by the client to the LHJ, the LHJ must refund the client the proper amount in a timely manner. Refunds are considered prompt when made within 30 days of notice of denial from Medicare or within fifteen days after a determination on an appeal if an appeal is made.

GA Modifier

The GA modifier indicates that a waiver of liability statement is on file with the LHJ. The GA modifier should be used with the ABN on Form CMS-1500 when the claim is billed to Medicare.

Stay Informed

Medicare reimbursement rates change periodically. Providers are encouraged to enroll in a relevant CMS electronic mailing list at www. cms.gov/AboutWebsite/20 EmailUpdates.asp.

Chapter 5

Billing Medicaid





5. Billing Medicaid

Medicaid in Washington

Medicaid is the nation's single largest source of health insurance for children and adults. Since 1965, Medicaid has been administered by Washington State through a cost share with the federal government. Unlike the Medicare entitlement program, Medicaid is a means-tested, needs-based social welfare or social protection program rather than a social insurance program. Some people are eligible for both Medicare and Medicaid. "Medical Assistance" is the general name for Washington's healthcare programs which are administered by the Department of Social and Health Services.

Medicaid is available only to certain low-income individuals and families who qualify for an eligibility group as determined by each state. Benefit packages for particular groups range from complete major medical to family planning or other specific services only. Usually, Medicaid reimbursement is considered payment in full.

The Department of Social and Health Services (http://hrsa.dshs.wa.gov) eligibility and enrollment information to people interested in obtaining Medicaid coverage. Special benefit packages are available to children in certain circumstances based on the child's status, not the parent's. Claims for Medicaid services are paid by the DSHS ProviderOne System through the Medicaid Payment Administration (MPA).

- The primary Web portal for health care providers in Washington State is ProviderOne http://hrsa. dshs.wa.gov/providerone.
- For more information about Medicaid at the federal level visit www.cms.gov/ MedicaidGenInfo

Immunizations and Medicaid

Immunizations are important to Medicaid populations which are considered to have an elevated risk of communicable disease. Medicaid services are made available by the Department of Social and Health Services (DSHS) through managed care, called Healthy Options, or as feefor-service. Client participation is divided about 50-50 between the two different methods.

Healthy Options provides no cost healthcare services for people on Medicaid or receiving Temporary Assistance for Needy Families (TANF).

i www.gwumc.edu/sphhs/departments/healthpolicy/ CHPR/downloads/Medicaid Immunization Study.pdf



Healthy Options plans cover immunizations except vaccines for international travel purposes only. The pediatric benefit includes all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Healthy Options currently offers a choice between seven health care plans. Healthy Options clients do not need a referral in order to be seen by LHJs for immunization, STDs, TB, and family planning. Feefor-service beneficiaries of immunization services may also self-refer. LHJs bill for immunization directly through the ProviderOne System for feefor-service clients and the Healthy Option plan for managed care clients.

LHJs are required to accept Medicaid's reimbursement rate as the full payment amount and are not allowed to charge any variance or balance remaining to the client. A write-off or adjustment must be made (see Chapter 2. Billing Basics).

Become a Medicaid Provider

In 2010, ProviderOne became the Department of Social and Health Services (DSHS) primary provider payment system. ProviderOne consolidates virtually all of the agency's health-care and social service provider billings and payments. All medical transactions, including vaccines and their administration, can now be processed in ProviderOne, including claims, eligibility inquiries, and adjustments.

The following ProviderOne and DSHS online resources may be of particular interest to LHJs:

- Access the ProviderOne information page for providers at http://hrsa.dshs. wa.gov/providerone/providers.htm.
- The ProviderOne System User Manual is available at http://hrsa.dshs.wa.gove/ providerone/Provider%20System%20 User%20Manual%20.htm.
- The ProviderOne training page offers live webinars, manuals and recorded step-by-step instructions called E-Learning at http://hrsa.dshs.wa.gov/ providerone/Provider%20Training.htm.
- The ProviderOne Billing and Resource Guide contains important general billing information at http://hrsa. dshs.wa.gov/download/ProviderOne_ Billing and Resource Guide.html.

- The information on injectable drugs in the Physician-Related Services/Healthcare **Professional Services Billing Instructions** provides information on billing Medicaid for immunization of adults at http://maa. dshs.wa.gov/download/Billing Instructions Webpages/Physician-Related Services.html.
- The information on injectable drugs in the Early Periodic Screening, Diagnosis & Treatment (EPSDT) Program Billing Instructions provides information on billing immunization for individuals under 21 years of age at http://maa.dshs.wa.gov/ download/Billing Instructions Webpages/ Physician-Related Services.html.

Security Requirements

In order to enroll in Medicaid, your organization must first identify a ProviderOne security administrator and obtain log on credentials from DSHS. DSHS will provide one initial logon domain, username and password for each National Provider Identifier (NPI) you have reported to DSHS. To obtain initial security credentials, the security administrator should email provideronesecurity@dshs.wa.gov with the subject line "Request for Provider Supplemental Information Request Form." Complete one form for each "pay to" NPI for your organization.

More information on the security process can be found at http://hrsa.dshs.wa.gov/providerone/ Security.htm.

At the completion of the security process, the security administrator will be able to add and manage additional ProviderOne users and assign profiles to them. A list of ProviderOne security profiles is available online (http://hrsa.dshs. wa.gov/providerone/documentation/Security/ EXT%20Provider%20security%20Profiles.doc). Each staff member will be assigned one or more of these profiles for the appropriate access to ProviderOne. Profiles control the actions you can do and data you can access.

For example, staff with the appropriate security profile can:

- Complete initial registration activities
- Maintain the organizations provider file (changes to contact information, associated providers, taxonomies, etc.)
- Submit claims
- Check client eligibility
- Access remittance advices

Additional ProviderOne readiness activities depend on transactions and provider type. http://hrsa.dshs.wa.gov/providerone/ Registration.htm for instructions to guide you through the appropriate steps for security, registration and testing activities for direct data entry, HIPAA batch files, providers who use a billing agent or clearinghouse, and others.

ProviderOne Fnrollment Basics

The ProviderOne security process enables you to begin an enrollment application for your organization. Access the enrollment application at www.waproviderone.org/ecams/jsp/common/ pgNewPrvdrEnrollment.jsp. The ProviderOne Enrollment "Business Process Wizard" will guide you through a series of required steps.

Before accessing the Business Process Wizard, you must identify your organization as one of the following provider types: Individual; Group; Attending/Servicing, Facility/Agency/ Organization/Institution, Tribe, or Billing Agent/ Clearinghouse. LHJs will generally select "Fac/ Agncy/Orgn/Inst." If you need assistance choosing which provider type to enroll as, contact Provider Enrollment at 1-800-562-3022 ext. 16137. Have your NPI number ready when you call.

The first step of the Wizard involves entering basic information such as:

- Tax ID
- **Organization Name**
- Federal Tax ID Number
- NPI (National Provider Identifier): Providers have an NPI obtained from the Centers for Medicare and Medicaid Services (CMS) and reported to DSHS. Use your group NPI in the appropriate locations and you Attending Provider NPI in the appropriate locations.
- UBI (Unified Business Identifier)
- W-9 Entity Type
- Other Organizational Information

Complete instructions on using the Business Process Wizard refer to the manual, Enrolling as a Facility, Agency, Organization Provider (http:// hrsa.dshs.wa.gov/providerone/Provider%20 System%20User%20Manual.htm)

Application Tracking

Resume or track a ProviderOne application at www.waproviderone.org/ecams/jsp/common/ pgTrackPrvdrApplctn.jsp. You will need your Application ID and either the Social Security Number (SSN) or Federal Employer Identification Number (FEIN) to log back in.







Provider Location

Every provider enrolling with an NPI number must have an NPI "base location" which is identified by three addresses: 1) the physical location; 2) the mailing address; and 3) the pay-to address. The NPI base location is used to anchor all of the provider's NPI-related specializations and related details. In situations where an LHJ utilizes multiple locations, each additional office or clinic is referred to as a NPI "servicing location" and referenced by two addresses: the location and mailing addresses.

Provider Taxonomy

In the medical billing and payment world, "provider taxonomy" refers to the national provider classification system defined by the Centers for Medicare and Medicaid Services (CMS). This national classification system was defined as part of the National Provider Identification (NPI) rule of the

Health Insurance Portability and Accountability Act (HIPAA). The national provider taxonomy codes identify a provider's type and area of specialization.

One of the top reasons claims are denied in ProviderOne is for missing or incorrect taxonomy codes. DSHS assigns one or multiple national provider taxonomy to each NPI based on type and specialty. These national codes are a subset of the national provider taxonomy codes that are recognized as valid for DSHS-covered services and payment. DSHS taxonomy codes are 10 characters in length and include both letters and numerals. The first two digits are provider type, the next two digits are provider specialty, and the next five digits are provider subspecialty. The last character is reserved for future use so it will display as an "X."

Taxonomy codes:

- Identify a provider's type and area of specialization for the services being billed.
- Must be associated with the provider file AND the service you are billing must be allowed under the taxonomy.
- Are required on claims for billing providers.
- Are required on claims for servicing providers, if applicable.
- Are not required for either the referring or attending provider.

Tips:

- a. Review the recorded webinar or PowerPoint slides on Billing Using Taxonomies on Claims on the training page at http://hrsa.dshs.wa.gov/ providerone/Provider%20Training.htm.
- **b.** Read the fact sheet Using Taxonomy in ProviderOne at http://hrsa.dshs. wa.gov/providerone/Providers/Fact%20 Sheets/P1PR009%20taxonomy.pdf.
- c. Numbered Memo 10-22 contains details on taxonomy code requirements and instructs where to place them on a claim at http://hrsa.dshs.wa.gov/download/ Memos/2010Memos/10-22.pdf.
- **d.** DSHS maintains a ProviderOne taxonomy tool that allows Washington State healthcare providers to review and print the taxonomies on their DSHS provider file. The tool is for viewing only and is located at https://fortress.wa.gov/dshs/ npicaphrsa/P1Taxonomy/StartPage.aspx.

DSHS has no way of knowing which taxonomies were used if you registered your NPI at the national level—there is no national database for accessing taxonomies from CMS.

Billing with Taxonomy Codes

LHJs should bill using the taxonomy code(s) associated with their file in ProviderOne that was validated during the enrollment process. During claims processing, ProviderOne will also validate that the taxonomy is associated with the provider and that the service is allowed by the taxonomy. ProviderOne claims processing is specific to the 10-digit taxonomy. If you have a general and specialty taxonomy assigned, you should choose the one that is most descriptive of the service.

Electronic Data Interchange (EDI)

EDI refers to electronic transmission of data over computer networks for Medicaid. EDI Information is required for LHJs utilizing FTP Secured Batch or Web Batch submittals/retrievals or intending to retrieve Prior Authorizations Forms known as "835s."

EDI Submission Method

There are four possible EDI submission methods: Web Batch; Billing Agent/Clearinghouse; FTP Batch and Web Interactive. Multiple modes of submission can be linked to each NPI. Web Batch is most often used by providers who submit their own HIPAA batch transactions. FTP Secured Batch

is used for submitting and retrieving batches at a secure web folder assigned to you by DSHS. This method was designed with clearinghouses and billing agents in mind.

Servicing Provider Information

The Servicing Provider is the person who actually provides the health care services rather than the organization or group, such as the LHJ. Servicing Providers are identified by their NPI, ProviderOne ID and Social Security numbers. If a provider does not exist in the database, you will be prompted to add that person.

See "How to Enroll a Servicing Provider" at http://hrsa.dshs.wa.gov/providerone/Provider%20
System%20User%20Manual.htm for more information.

Types of Medicaid Coverage

Benefit Services Packages are different types of coverage offered through the Medicaid program. A complete list of types and their descriptions is contained in Appendix E of the ProviderOne Billing and Resource Guide (http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html).

At the time of publication, DSHS maintained 13 different benefit services packages to meet a wide diversity of needs including family planning and

the coverage of Medicare premiums. Examples of packages include:

- QMB (Qualifying Medicare Benefits Only)
- Family Planning Only
- Primary Insurance and Medicaid
- CNP (Categorically Needy Program)
- GAU (General Assistance—Unemployable)
- LCP—MNP (Limited Casualty Program— Medically Needy Program)

The Categorically Needy Program (CNP) has the largest scope of care and includes services such as doctors, dentists, physical therapy and eye exams. By contrast, the Emergency Related Services Only (ESRO) program has coverage for a specific medical condition. Prior authorization may be required and services not related to the medical condition are not covered.

When you identity someone through the client eligibility verification process, ProviderOne will display that person's Benefit Services Package and list all of their covered services.

Client Eligibility Verification

Each family member covered by Medicaid gets a "Services Card." The Services Card is a permanent card that is active while an individual is eligible for medical assistance. The card only includes the client's name and ID number. Verify each client's Medicaid eligibility prior to providing services.







Figure 5.1. State of Washington Services Card

Take note that eligibility information in ProviderOne is not overwritten. If the client shows a particular coverage on the day of service, and later that coverage changes, the previous eligibility information will still be visible. It's highly recommended for health departments to capture and retain the eligibility screen shot at the time that service is rendered. This proof of eligibility will be useful if the claim is denied. Eligibility denials are particularly common with Medicaid and reprocessing with additional documentation is often necessary.

Access ProviderOne to submit an eligibility inquiry using one of these methods:

- Search for eligibility information via ProviderOne at www.waproviderone.org.
- Submit an electronic individual or batch 270/271 inquiry to ProviderOne.
- Swipe the client services card using a magnetic card reader.

- Use a Medical Eligibility Vendor to access information on your behalf (See ProviderOne Billing and Resource Guide Appendix H).
- Alternative methods for checking eligibility are available:
 - Call the Interactive ProviderOne Voice Response (IVR) (See ProviderOne Billing and Resource Guide Appendix B).
 - Call a customer service representative at 1-800-562-3022.

If a client has lost the Services Card, call the Medical Assistance Helpline at 1-800-562-3022. Medical assistance coverage is not transferable. If you suspect that a client has presented a Services Card belonging to someone else, request to see a photo ID or another form of identification.

i http://hrsa.dshs.wa.gov/download/ ProviderOne Billing and Resource Guide.html ii http://hrsa.dshs.wa.gov/download/ ProviderOne Billing and Resource Guide.html



Figure 5.2. Check for eligibility using ProviderOne's benefit inquiry search feature

Follow the additional steps described in the Client Eligibility, Benefit Packages, and Coverage Limits section of the ProviderOne Billing and Resource Guide for more information on the topic of eligibility and getting paid for services covered through Medical Assistance. Watch a recorded webinar or Powerpoint slides, Interpreting Client Eligibility Information, at http://hrsa.dshs.wa.gov/providerone/Provider%20Training.htm.

Magnetic Card Readers

To use the optional readers for the Services Cards, an LHJ will need: (1) a reader compatible with the Services Cards and the network used by ProviderOne for eligibility data; and (2) a monthly subscription to the eligibility data. The magnetic card readers (with a monthly subscription) allow providers to "swipe" the Services Card and immediately receive eligibility information. There are at least two kinds of card readers.



 Mini Magnetic Card Readers attach to a computer via a USB connection. Internet access is required. Eligibility information is accessed through secure login to the vendor's website and seen on the computer screen. Providers can print the screen.



 Desktop Magnetic Card Readers use either the Internet or an analog phone line to send inquiries and receive eligibility information. Eligibility information is printed line by line similar to a cash register or credit card receipt.

If a provider purchases a compatible reader and intends to use it only to access eligibility information through ProviderOne, they will likely be able to install it without outside assistance. DSHS does not provide, sell, or endorse card readers. If your LHJ chooses to purchase a card reader, shop for the vendor and model that best meets your needs.

i http://hrsa.dshs.wa.gov/download/ ProviderOne Billing and Resource Guide.html



To ensure that providers would have at least one option for a reader compatible with the Services Card, the vendor for ProviderOne is required to make readers available for purchase by providers who request them.

Visit the MedData website for detailed information compatible models, specifications, and the eligibility subscription service: www. meddatahealth.com/MedData/ProviderOne or call MedData at 1-877-633-3282. You may also send inquiries to support@meddatahealth.com.

Medicaid Claims and Billing

The "Submit Fee-for-Service Claims to Medical Assistance" section of the ProviderOne Billing and Resource Guide describes the following key steps in submitting a claim to DSHS for Medicaidcovered services:

- 1. Determine the claim submission method
- 2. Determine if a claim needs backup
- 3. Submit new claims and backup via direct data entry into ProviderOne, online batch claims submission, and paper
- 4. Submit Medicare cross-over claims
- 5. Inquire about the status of a claim
- 6. Adjust, resubmit or void a claim

Medicaid providers currently have up to one year to file a claim for reimbursement but if a claim has been denied, the provider has up to three years to seek reimbursement. LHJs are required to accept Medicaid's reimbursement rate as the full payment amount and are not allowed to charge any variance or balance remaining to the client. A write off or adjustment must be made instead.

Once you are familiar with DSHS billing requirements for Medicaid, you can access ProviderOne directly by clicking "Use Provider One" at the top of the ProviderOne home page at http://hrsa.dshs.wa.gov/providerone.

Medicaid is always the last payer so be sure to determine if another payer exists. You will be required in most instances to submit an Explanation of Medicare Benefits (EOMB) from Medicare or an Explanation of Benefits (EOB) from another primary insurer as backup to Medicaid claims. If Medicare NEVER covers a procedure code, you can bill it directly to Medicaid. If Medicare sometimes covers the service, Medicare must be billed first.

Common billing pitfalls include failing to include required back up information with your claim or billing services to DSHS that were not first billed to the primary payer.

Paper Claim Submission

If you intend to bill Medicaid on paper, follow the "Tips for Successful Paper Billing" at http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20 Sheets/P1PR018.pdf. Paper billing requires the use of CMS-1500 claim forms. Medicare crossover claims are also submitted on the CMS-1500 form. The only acceptable claim forms are printed in Flint J-6983 Red OCR ink (or exact match).

Direct Data Entry (DDE)

ProviderOne enables you to electronically submit new claims, check claim status, submit adjustment claims, revive denied claims, and attach electronic backup documentation to claims. Processing of DDE claims is much more rapid than that of paper claims. Billing electronically, either through a HIPAA-compliant batch claim (through a billing agent or clearinghouse) or keying directly into ProviderOne, is always faster. Claims entered online are often paid within one week whereas paper claims can take up to 45 days to process.

Billing Medicaid Clients

There are limited circumstances in which a provider may bill a Medicaid client for covered or noncovered services. The Agreement to Pay

for Healthcare Services (DSHS 13-879 form) documents when these limited circumstances are met. The signed and completed form must be kept on file for six years in case of an audit.

The DSHS 13-879 form was created through when DSHS revised WAC 388-502-0160, Billing a Client, effective May 27, 2010. This important revision, summarized at http://hrsa.dshs.wa.gov/download/memos/2010Memos/10-25.pdf, also:

- Specifies the limited circumstances in which a fee-for-service or managed care client may choose to self-pay for healthcare services using the DSHS 13-879 form;
- Specifies the limited circumstances in which a provider may bill a fee-for-service client without a signed DSHS 13-879 form; and
- Identifies circumstances in which a provider may not bill a client even when the client has signed DSHS 13-879 form.
- Describes the circumstances when a provider must refund a client's payment.

For clients with limited English proficiency, the DSHS 13-879 form must be the version translated in the client's primary language. If necessary, this form must also be interpreted for the client. If the agreement is interpreted, the interpreter must also sign it. All other requirements for the DSHS 13-879 form apply.



Agreement to Pay for Healthcare Services

WAC 388-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) for which the Department of Social and Health Services (DSHS) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

- 1. Client is a recipient of Medicaid or other healthcare benefits through the DSHS or a managed care organization (MCO) that contracts with DSHS; and
- 2. Provider is an institution, agency, business, or person that furnishes healthcare services to DSHS clients and has a signed agreement with DSHS or authorization from an MCO.

This Agreement and WAC 388-502-0160 apply to billing a client for covered and noncovered services as described in WAC 388-501-0050 through WAC 388-501-0070. Providers may not bill any DSHS client (including those enrolled with an MCO that contracts with DSHS) for services which DSHS or an MCO that contracts with DSHS may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S DSHS ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

This form:

- . Must be fully completed by both the provider and the client before any service for which this Agreement is required is provided to a DSHS client.
- Must be completed no more than 90 calendar days before the service is provided. If the service is not provided within 90 calendar days, a new form must be completed and signed by both the provider and the client.
- Must be completed only after the provider and the client have exhausted all applicable DSHS or DSHS-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 388-501-0160 or the administrative hearing process as described in WAC 388-526-2610, if the client chooses to pursue these processes
- . Must be understandable to a limited English proficient (LEP) client in his or her primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. A translated form must be signed by both the client and the provider.

The table on back of this form must be fully completed. If needed, attach another sheet for additional services. Each additional page must be signed and dated by the client, provider, and interpreter (if applicable).

- . This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 388-502-0160 or does not satisfy DSHS conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- . See WAC 388-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. A copy of this completed, signed agreement must also be given to the client.
- · Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at http://www.dshs.wa.gov/msa/forms/eforms.html.

AGREEMENT TO PAY FOR HEALTHCARE SERVICES DSHS 13-879 (05/2010)

Page 1 of 2

Figure 5.3. Agreement to Pay for Healthcare **Services** Form (DSHS 12-879)



The Agreement to Pay for Healthcare Services form, DSHS 13-879 (including translated versions) may be found at http://www.dshs.wa.gov/msa/forms/eforms.html.

Providers are responsible for verifying:

- The client is eligible to receive medical assistance services on the date that services are provided.
- Whether the client is enrolled with a DSHScontracted managed care organization (MCO).
- Limitations on services within the scope of the eligible client's medical program (WAC 388-501-0050(4)(a) and 388-501-0065).
- The client is informed of the limitations on the specific service(s) requested.

- All applicable DSHS or DSHScontracted MCO processes necessary to obtain authorization for the requested services are exhausted.
- That translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services.
- That all DSHS or DSHS-contracted MCO requirements have been fulfilled. The provider must keep on file all documentation proving fulfillment of those requirements.

Learn more about billing a client through the webinar and slide presentation at http://maa.dshs.wa.gov/pdf/provider/Webinar/BillingaClientFinal. pdf.

Remittance Advice

A remittance and status report (RA) is a report produced by DSHS claims processing system (known as the Medicaid Management Information System

or MMIS) that provides detailed information concerning submitted claims and other financial transactions. Clearinghouses refer to RAs as "835s." You can view and upload RAs from ProviderOne, and the information contained in RAs is also searchable.



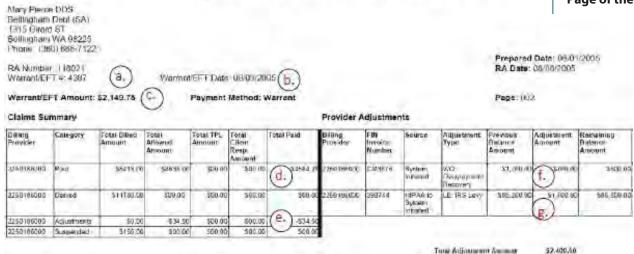
Figure 5.4. **Front Page** of the RA

Torse Addisonwers Assessed



Department of Social Health Services Remittance Advice

Figure 5.5. **The Summary** Page of the RA





On the summary page of the RA:

- a. Check number.
- **b.** Date of payment.
- **c.** Total payment you received on your check (warrant) or EFT.
- d. Total of the paid claims on this RA.
- **e.** Deduction due to a claim adjustment from the total paid amount.
- **f.** Deduction due to an audit overpayment (\$700).
- g. Deduction due to an IRS Lien (\$1700).

Read more about RAs at http://hrsa.dshs.
wa.gov/download/ProviderOne_Billing_and_Resource_Guide/DSHS_RA.pdf.

ProviderOne answers frequently asked questions about RAs at http://hrsa.dshs.wa.gov/providerone/Providers/Q&A/FAQRemittanceAdvice.pdf.

Completing the CMS-1500 Claim Form

All Medicaid claims are submitted using the CMS-1500 claim form through ProviderOne. Refer to the ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 Claim Form.

Medical Coding for Medicaid

Medicaid billing requires the use of Current Procedure Terminology (CPT®); and Level II Healthcare Common Procedure Coding System (HCPCS) for services related to immunization and other injectable drugs. Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all Medicaid covered services.

Modifiers

When multiples of the same procedure are performed on the same day, providers must bill with the appropriate modifier. They must bill all the services on the same claim form to be considered for payment. Modifying numbers and letters are separated from the primary code with a dash, e.g. 99211-25 or 90700-SL.

25

If an immunization is the only service provided, use the CMS-1500 form to bill only for the administration of the vaccine and the vaccine itself (if appropriate). If a significant and separately identifiable condition exists and is reflected by the diagnosis, bill the Evaluation and Management (E&M) code with modifier 25. If you bill the E&M code without modifier 25 on the same date of service as a vaccine administration, DSHS will deny the E&M code.

However, if an immunization is the only service provided (e.g., an immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25 (as 99211-25). The brief history must be documented in the client record. Note that meningococcal vaccines (CPT procedure codes 90733 and 90734) require eligibility preauthorization.

SL

The SL modifier must be used with immunization procedure codes to identify the vaccines are obtained from the Department of Health (DOH).

Medicaid Fee Schedules

The DSHS fee schedule for immunization and travel vaccines can be accessed at under "Injectable Drugs" via a link at http://hrsa.dshs.wa.gov/ RBRVS/Index.html. Billing does not distinguish between "travel only" and vaccinations for other reasons.



Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a preventive health care benefit for children and youth. The program provides complete, periodic health screenings to clients under age 21. The screenings can help identify potential physical and/or behavioral health conditions. Diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program.

When requested, screenings are done according to a recommended schedule to fully assess each

child's health status and find possible health problems. A screening includes all of the following elements:

- Complete health and developmental history
- A full physical examination
- Appropriate behavioral health and substance abuse screening
- Health education and counseling based on age and health history
- Appropriate vision testing
- Appropriate hearing testing
- Appropriate laboratory testing
- Dental screening services
- Immunization (shots)

All EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening.

LHJs can bill for services related to EPSDTsuch as laboratory work, hearing tests, x-rays, or immunization administration—using the appropriate procedure and screening code(s) (99381 - 99395) on the same CMS-1500 claim form. Use the appropriate diagnosis code when billing any EPSDT screening service (99381-99395).

When physicians and ARNPs identify problems during a screening examination, they may treat the client or may refer the client to another provider. Physicians and ARNPs are not limited to the procedure codes listed in the EPSDT billing instructions.ⁱ They may also use the current Physician-Related Services (RBRVSii) Billing Instructions as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of follow-up treatment must be billed on a separate CMS-1500 form from the screening examination.

Refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions for immunization billing information for clients under 21 years of age at http://hrsa. dshs.wa.gov/download/Billing Instructions Webpages/EPSDT.html.

Immunizations covered under the EPSDT program are listed in the EPSDT Fee Schedule available at http://hrsa.dshs.wa.gov/RBRVS/Index.html.

Clients 18 Years of Age and Younger—Vaccine "Free from DOH"

The Washington State Childhood Immunization Program supplies free vaccines to enrolled providers for children 0-18 years only. For the current list of No Cost Immunizations, contact the immunization coordinator in your office or check the Immunization and Child Profile Office website at www.doh.wa.gov/cfh/immunize.

Bill for the administration only by reporting the procedure code for the vaccine along with the SL modifier (e.g. 90707-SL). DSHS pays \$5.96 per dose for the administration of each of these vaccines provided from DOH. Do not bill CPT codes 90471-90472 for administration.



i http://hrsa.dshs.wa.gov/download/Billing_ Instructions Webpages/EPSDT.html ii RBRVS stands for "Resource Based Relative Value Scale."

Clients 18 Years of Age and Younger—"Not Free from DOH"

Bill DSHS for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use the SL modifier with these vaccines. DSHS pays for the vaccine using the maximum allowable fee schedule.

Bill DSHS for the vaccine administration using either CPT codes 90471 or 90472. Payment for immunization administration is limited to a maximum of two administration codes (e.g., one unit of 90471 and one unit of 90472). Providers must bill administration codes on the same claim form as the procedure code for the vaccine.

Clients 19-20 Years of Age

Bill DSHS for the cost of the vaccine itself by reporting the procedure code for the vaccine given. (DO NOT use the SL modifier with any of the vaccines for clients 19-20 years of age.) DSHS pays for the vaccine using the maximum allowable fee schedule. Bill using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to one unit of 90471and one unit of 90472 (maximum of two vaccines). Providers must bill 90471 and 90472 on the same claim as the procedure code for the vaccine. The Medicare Q codes used for administration of influenza vaccine (see page 66) are now also

required by Medicaid. The Q codes replace the influenza vaccine CPT code 90658. This does not apply for administration of influenza vaccine to Medicaid children less than 19 years of age.ⁱ

Clients 21 Years of Age and Older

The Department of Health supplies free vaccines for children 0-18 years only. For older clients, you can bill for the cost of the vaccine itself by reporting the procedure code for the vaccine given. ProviderOne reimburses providers for the vaccine using the maximum allowable fee schedule. However, immunization services may not always be a covered benefit for this age group.

Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines). Providers must bill 90471 and 90472 on the same claim as the procedure code for the vaccine.

Dosage Based Assessment (DBA) Billing

DBA billing process does not apply to any Medicaid claims (See page 16).

i http://hrsa.dshs.wa.gov/Download/ Billing Instructions/Physician-Related Svcs/Section C.pdf



Additional Resources

Be sure to check the Washington State Medicaid Providers website for updates to billing procedures and forms http:// hrsa.dshs.wa.gov/provider.

Select the "Medicaid Forms" link or go directly to http://hrsa.dshs.wa.gov/mpforms.shtml. Some forms that were previously DSHS forms now belong to the Washington State Health Care Authority (HCA). If you do not find the form you need on the DSHS site, please select the Medicaid Forms link. If you are still not able to locate the desired form, contact Health Care Authority Print and Productions Services at ASKMEDICAID@dshs.wa.gov for assistance.

Stay Informed

The Medicaid Program offers a variety of learning opportunities for providers at http:// hrsa.dshs.wa.gov/provider/training.shtml.

Review the Discovery log for known issues and workarounds at http://hrsa.dshs.wa.gov/ ProviderOne/documentation/DiscoveryLog.xls.

Sign up for an email list for ProviderOne at http://listserv.wa.gov/archives/ providerone_provider_readiness.htm.

Sign up for other DSHS email lists for information about policy, rates, and other information at https://fortress.wa.gov/dshs/hrsalistsrvsignup.

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Appendices

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- D. JCPH Community Health Fees
- E. Spokane Health District Fee Policy
- F. JCPH Traveler Adult Fee
- G. BFPH Unclaimed Property
- H. DBA Sample Forms
- JCPH Immune Globulin After Hep A ١.
- Kinship Caregiver Declaration
- K. Spokane Write Off Policy
- L. Agreement to Pay Form Benton Franklin
- M. Client Registration Form
- N. Credentialing Information Sheet
- O. Encounter Form Jefferson
- P. Encounter Form WallaWalla
- Q. Fee Waiver for Financial Hardship Form
- R. Immunization Consent Grays Harbor
- S. Immunization Consent Spokane
- T. Immunization Consent Jefferson
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A. Glossary

AMA - American Medical Association. The AMA is the largest association of doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

Aging – One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software's have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

Appeal – When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance providers web site.

Applied to Deductible – You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

Assignment of Benefits – Insurance payments that are paid to the doctor or hospital for a patients treatment.

Beneficiary – Person or persons covered by the health insurance plan.

Capitation - A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients health care services. This payment is not affected by the type or number of services provided.

Charity Care - When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay.

Clean Claim - Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

Clearinghouse – This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards (this is one of the medical billing terms we see a lot more of lately).

CMS - Centers for Medicaid and Medicare Services. Federal agency which administers Medicare, Medicaid, HIPPA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration). You'll notice that CMS it the source of a lot of medical billing terms.

CMS 1500 - Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on CMS-1500's. The form is distinguished by it's red ink.

Coding – Medical Billing Coding involves taking the doctors notes from a patient visit and translating them into the proper ICD-9 code for diagnosis and CPT codes for treatment.

Co-Insurance - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example the insurance carrier pays 80% and the patient pays 20%.

Collection Ratio - This is in reference to the providers accounts receivable. It's the ratio of the payments received to the total amount of money owed on the providers accounts.

Contractual Adjustment – The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

Coordination of Benefits - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

Co-Pay – Amount paid by patient at each visit as defined by the insured plan.

CPT Code – Current Procedural Terminology. This is a 5 digit code assigned for reporting a procedure performed by the physician. The CPT has a

corresponding ICD-9 diagnosis code. Established by the American Medical Association. This is one of the medical billing terms we use a lot.

Credentialing – This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks.

Credit Balance – The balance that is shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example \$50-). It may also be shown in parenthesis; (\$50). The provider may owe the patient a refund.

Crossover claim - When claim information is automatically sent from Medicare the secondary insurance such as Medicaid.

Date of Service (DOS) – Date that health care services were provided.

Deductible – amount patient must pay before insurance coverage begins. For example, a patient could have a \$1000 deductible per year before their health insurance will begin paying. This could take several doctor's visits or prescriptions to reach the deductible.

Demographics – Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

DOB – Abbreviation for Date of Birth

Downcoding – When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurers computer processing system converts the code submitted down to the closest code in use which usually reduces the payment.

Duplicate Coverage Inquiry (DCI) - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

Dx - Abbreviation for diagnosis code (ICD-9 or ICD-10 code).

Electronic Claim - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

Electronic Funds Transfer (EFT) - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

E/M - Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians to access (or evaluate) a patients treatment needs.

EMR - Electronic Medical Records. Also referred to as EHR (Electronic Health Records). This is a medical record in digital format of a patients hospital or provider treatment.

Enrollee – Individual covered by health insurance.

EOB – Explanation of Benefits. One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

ERA - Electronic Remittance Advice. This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard.

Fee For Service - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

Fee Schedule - Cost associated with each treatment CPT medical billing codes.

Financial Responsibility - The portion of the charges that are the responsibility of the patient or insured.

Fiscal Intermediary (FI) – A Medicare representative who processes Medicare claims.

Formulary – A list of prescription drug costs which an insurance company will provide reimbursement for.

Fraud – When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

Group Name – Name of the group or insurance plan that insures the patient.

Group Number – Number assigned by insurance company to identify the group under which a patient is insured.

Guarantor – A responsible party and/or insured party who is not a patient.

HCFA – Health Care Financing Administration. Now know as CMS (see above in Medical Billing Terms).

HCPCS – Health Care Financing Administration Common Procedure Coding System. (pronounced "hick-picks"). Three level system of codes. CPT is Level I. A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a procedure code in the medical billing glossary.

The three HCPCS levels are:

- Level I American Medical Associations Current Procedural Terminology (CPT) codes.
- Level II The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- Level III Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

Healthcare Insurance - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy which covers the beneficiary's family members. May include coverage for disability or accidental death or dismemberment.

Heathcare Provider - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage.

Health Care Reform Act – Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. Also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

HIC - Health Insurance Claim. This is a number assigned by the the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

HIPAA - Health Insurance Portability and Accountability Act. Several federal regulations intended to improve the efficiency and effectiveness of health care and establish privacy and security laws for medical records. HIPAA has introduced a lot of new medical billing terms into our vocabulary lately.

HMO – Health Maintenance Organization. A type of health care plan that places restrictions on treatments.

ICD-9 Code – Also know as ICD-9-CM. International Classification of Diseases classification system used to assign codes to patient diagnosis. This is a 3 to 5 digit number.

ICD 10 Code - 10th revision of the International Classification of Diseases. Uses 3 to 7 digit. Includes additional digits to allow more available codes. The U.S. Department of Health and Human Services has set an implementation deadline of October, 2013 for ICD-10.

Indemnity – Also referred to as fee-for-service. This is a type of commercial insurance were the patient can use any provider or hospital

In-Network (or Participating) – An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

MAC - Medicare Administrative Contractor.

Managed Care Plan - Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

Maximum Out of Pocket - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

Medical Assistant - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physicians assistant, nurse, nurse practitioner, etc.

Medical Coder - Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-9 codes (soon to be ICD-10) and corresponding CPT treatment codes and any related CPT modifiers.

Medical Billing Specialist – Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology.

Medical Necessity – Medical service or procedure that is performed on for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

Medical Record Number - A unique number assigned by the provider or health care facility to identify the patient medical record.

MSP - Medicare Secondary Payer.

Medical Savings Account – Tax exempt account for paying medical expenses administered by a third party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account.

Medicare – Insurance provided by federal government for people over 65 or people under 65 with certain restrictions. There are 2 parts:

- Medicare Part A Hospital coverage
- Medicare Part B Physicians visits and outpatient procedures
- Medicare Part D Medicare insurance for prescription drug costs for anyone enrolled in Medicare Part A or B.

Medicare Coinsurance Days - Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

Medicaid – Insurance coverage for low income patients. Funded by Federal and state government and administered by states.

Modifier - Modifier to a CPT treatment code that provide additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

N/C - Non-Covered Charge. A procedure not covered by the patients health insurance plan.

Network Provider – Health care provider who is contracted with an insurance provider to provide care at a negotiated cost.

Nonparticipation – When a healthcare provider chooses not to accept Medicare-approved payment amounts as payment in full.

NOS – Not Otherwise Specified. Used in ICD for unspecified diagnosis.

NPI Number - National Provider Identifier. A unique 10 digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).

OIG - Office of Inspector General - Part of department of Health and Human Services. Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices.

Out-of Network (or Non-Participating) - A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of network provider.

Out-Of-Pocket Maximum - The maximum the patient must pay under insurance policy. Anything above this limit is the insurers obligation. Out-ofpocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

Outpatient – Typically treatment in a physicians office, clinic, or day surgery facility lasting less than one day.

Palmetto GBA - An administrator of Medicare health insurance for the Centers for Medicare & Medicaid Services (CMS) in the US and its territories. A wholly owned subsidiary of BlueCross BlueShield of South Carolina based in Columbia, South Carolina.

Patient Responsibility – The amount a patient is responsible for paying that is not covered by the insurance plan.

PCP - Primary Care Physician - Usually the physician who provides initial care and coordinates additional care if necessary.

POS - Point-of-Service plan. Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers. When a non-HMO specialist is seen without referral from the Primary Care Physician (self-referral), they have to pay a higher deductible and a percentage of the coinsurance.

POS (Used on Claims) – Place of Service. Medical billing terminology used on medical insurance claims - such as the CMS 1500 block 24B. A two digit code which defines where the procedure was performed. For example 11 is for the doctors office, 12 is for home, 21 is for inpatient hospital, etc.

PPO -Preferred Provider Organization. Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO.

Practice Management Software – software used for the daily operations of a providers office. Typically used for appointment scheduling and billing.

Preauthorization - Requirement of insurance plan for primary care doctor to notify the patient insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

Pre-Certification - Sometimes required by the patients insurance company to determine medical necessity for the services proposed or rendered. This doesn't guarantee the benefits will be paid.

Predetermination – Maximum payment insurance will pay towards surgery, consultation, or other medical care – determined before treatment.

Pre-existing Condition (PEC) – A medical condition that has been diagnosed or treated within a certain specified period of time just before the patients effective date of coverage. A Pre-existing condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

Pre-existing Condition Exclusion - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective. **Premium** – The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

Privacy Rule – The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health **Information (PHI).** PHI is any information on a patient about the status of their health, treatment, or payments.

Provider – Physician or medical care facility (hospital) who provides health care services.

PTAN – Provider Transaction Access Number. Also known as the legacy Medicare number.

Referral – When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

Remittance Advice (R/A) – A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits).

Responsible Party – The person responsible for paying a patients medical bill. Also referred to as the guarantor.

Revenue Code – Medical billing terminology for a 3-digit number used on hospital bills to tell the insurer where the patient was when they received treatment, or what type of item a patient received.

RVU – Relative Value Amount. This is the average amount Medicare will pay a provider or hospital for a procedure (CPT-4). This amount varies depending on geographic location.

Self-Referral – When a patient sees a specialist without a primary physician referral.

Self Pay – Payment made at the time of service by the patient.

Secondary Insurance Claim – claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

Secondary Procedure – When a second CPT procedure is performed during the same physician visit as the primary procedure.

Security Standard – Provides guidance for developing and implementing policies and procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

SOF – Signature on File.

Software As A Service (SAAS) – One of the medical billing terms for a software application that is hosted on a server and accessible over the Internet. SAAS relieves the user of software maintenance and support and the need to install and run an application on an individual local PC

or server. Many medical billing applications are available as SAAS.

Specialist – Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

Subscriber - Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder.

Superbill - One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-9 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

Supplemental Insurance – Additional insurance policy that covers claims fro deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

TAR - Treatment Authorization Request. An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

Taxonomy Code – Specialty standard codes used to indicate a providers specialty sometimes required to process a claim.

Term Date – Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

Tertiary Insurance Claim - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

Third Party Administrator (TPA) - An independent corporate entity or person (third party) who administers group benefits, claims and administration for a self-insured company or group.

TIN - Tax Identification Number. Also known as Employer Identification Number (EIN).

TOP - Triple Option Plan. An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

TOS – Type of Service. Description of the category of service performed.

UB04 - Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form.

Unbundling – Submitting several CPT treatment codes when only one code is necessary.

Untimely Submission – Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

Upcoding - An illegal practice of assigning an ICD-9 diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payor.

UPIN – Unique Physician Identification Number. 6 digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

Usual Customary & Reasonable(UCR) - The allowable coverage limits (fee schedule) determined by the patients insurance company to limit the maximum amount they will pay for a given service or item as defined in the contract with the patient.

Utilization Limit - The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit.

Utilization Review (UR) - Review or audit conducted to reduce unnecessary inpatient or outpatient medical services or procedures.

B. A	cronyms	DEM	Department of Emergency Management	
			Department of Health (State)	
AAR	After Action Report	DPT	Diptheria/Pertussis/Tetanus Vaccine	
AARP	American Association of Retired Persons	DRG	Diagnosis Related Group	
ABCD	Access to Baby and Child Dentistry	DSHS	Department of Social & Health Services (State)	
ABCDE	Access to Baby and Child Dentistry Expanded	DTaP	Diphtheria, Tetanus and Accellular Pertussis Vaccine	
ACIP	Advisory Committee on Immunization Practices	DTP	Diphtheria, Tetanus and Pertussis Vaccine	
ADA	American's with Disabilities Act	E&M	Evaluation and Management Service	
ADN	Alcohol Drug Network	EDI	Electronic Data Interchange	
AIDS	Acquired Immune Deficiency Syndrome	EFSS	Early Family Support Services (DCFS)	
AMA	American Medical Association	EIP	Early Intervention Program (DCFS)	
ANA	American Nurses Association	EMS	Emergency Medical Services	
APHA	American Public Health Association	ЕОВ	Explanation of Benefits	
APHL	Association of Public Health Laboratories	EPA	Environmental Protection Agency	
AWC	Association of Washington Cities	EPH	Environmental Public Health	
ВНР	Basic Health Plan	EPI	Epidemiology	
CA	Children's Administration (DCFS)	FDA	Food and Drug Administration	
CD	Communicable Disease	FEMA	Federal Emergency Management Agency	
CDC	Centers for Disease Control & Prevention (Federal)	FFS	Fee For Service	
CF	Conversion Factor	FP	Family Planning	
CHC	Community Health Center	FPL	Federal Poverty Level	
CHIP	Children's Health Insurance Program	FQHC	Federally Qualified Health Center	
CHLF	Community Health Leadership Forum	FS	First Steps	
CMS	Center for Medicare and Medicaid Services	GAU	General Assistance - Unemployable	
CNP	Categorically Needy Program	GPCI	Geographic Practice Cost Index	
CP	Child Profile	HAV	Hepatitis A Virus Vaccine	
CPS	Child Protective Services	HBV	Hepatitis B Virus Vaccine	
CPT	Current Procedural Terminology	НСА	Health Care Authority	
CSHCN	Children with Special Health Care Needs	HCCW	Healthy Child Care Washington	
cso	Community Service Offices (DSHS)	HCFA	Health Care Financing Administration (Federal)	
DBA	Dosage Based Assessment	HCPCS	HCFA Common Procedure Coding System	
DCFS	Division of Children and Family Services (DSHS)	HEDIS	Health Pan Employer Data and Information Set	
DEA	Drug Enforcement Administration Number			

HFA	Healthy Families America	MMR	Measles/Mumps/Rubella Vaccine
нна	Home Health Agency	MMWR	Morbidity and Mortality Weekly Report
HHS	Department of Health and Human Services Federal)	MNP	Medically Needy Program
Hib	Haemophilus Influenza, type b	MOU	Memorandum of Understanding
HIPAA	Health Insurance Portability & Accountability Act	MSA	Medical Savings Account
HIV	Human Immunodeficiency Virus	MSS	Maternity Support Services
нмо	Health Maintenance Organization	NACCHO	National Association of City and County Health Officials
но	Healthy Options	NACO	National Association of Counties
HPSA	Health Professional Shortage Area	NALBOH	National Association of Local Boards of Health
HPV	Human Papilloma Virus Vaccine	NCHS	National Center for Health Statistics
HRSA	Health Resources & Services Administration	NFP	Nurse Family Partnership
ICD-9-CM	International Classification of Diseases, 9th	NIH	National Institutes of Health (Federal)
	Revision, Clinical Modification	NIOSH	National Institute for Occupational Safety and Health (CDC)
ICM	Infant Case Management	NCQA	National Committee for Quality Assurance
ICS	Incident Command System	NPPES	National Plan & Provider Enumeration System
IDS	Integrated Delivery System	NPI	National Provider Identifier Number
IHS	Indian Health Service (Federal)	NPP	Notice of Privacy Practice
ISN	Integrated Service Network	NWCPHP	Northwest Center for Public Health Practice
IPA	Independent Practice Association	ОМВ	Office of Management & Budget
IPV	Inactivated Polio Vaccine	OSHA	Occupational Safety & Health Administration
ITN	Infant Toddler Network	PCCM	Primary Care Case Management
IVR	Interactive Voice Response	PCP	Primary Care Provider
L&I	Department of Labor and Industries (State)	PCV7	Pneumococcal Conjugate Vaccine
LCP	Limited Casualty Program	PEBB	Public Employee Benefits Board
LHD	Local Health Department or District	PH	Public Health
LHJ	Local Health Jurisdiction	PHELF	Public Health Executive Leadership Forum
LHO	Local Health Officer	PHEPR	Public Health Emergency Preparedness & Response
MAA	Medical Assistance Administration	PHIMS	Public Health Information Management System
MCBS	Medicare Current Beneficiary Survey	PHIN	Public Health Information Network
MCH	Maternal and Child Health	PHIP	Public Health Improvement Partnership
MCR	Medicare Cost Report	PHN	Public Health Nurse
MCV4	Meningococcal Conjugate Vaccine	РНО	Physician Hospital Organization
8451	Marking Francis Index		

MEI

Medicare Economic Index

PHS U.S. Public Health Service PIO **Public Information Officer**

POD Point of Dispensing POS Point of Service

PPO Preferred Provider Organization PPS **Prospective Payment System**

PRO Peer Review Organization

PSRO Professional Standards Review Organization

QA **Quality Assurance**

QMB Qualifying Medicare Beneficiary

RA Remittance Advice

RBRVS Resource-Based Relative Value Scale

RCW Revised Code of Washington

RHC Rural Health Center RVU Relative Value Unit State Board of Health **SBOH**

SFTP Secure File Transfer Protocol

SNF **Skilled Nursing Facility**

SSI Supplemental Security Income

SSN Social Security Number

STD Sexually Transmitted Disease

TANF Temporary Assistance for Needy Families

ТВ **Tuberculosis**

Td Tetanus, Diphtheria Vaccine

Tdap Tetanus, Diphtheria, and Pertussis Vaccine

TIN Tax Identification Number

Title xix Section of Social Security Act funding Medicaid Title xvIII Section of Social Security Act funding Medicare

UBI Unified Business Identifier Number UCR Usual, Customary and Reasonable

UR **Utilization Review**

VFC Vaccine for Children Program

VPS **Volume Performance Standards** WAC Washington Administrative Code

WACO Washington Association of County Officials WIC Women, Infant & Children Nutrition Program WSAC Washington State Association of Counties

WSALPHO Washington State Association of Local Public Health Officials

WSNA Washington State Nurses Association

WSPHA Washington State Public Health Association

WVA Washington Vaccine Association



C. JCPH Clinical Services Financial & Operations Guidelines

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JEFFERSON COUNTY PUBLIC HEALTH

DEPARTMENT: Jefferson County P		DIVISION: Community Health		SECTION OF MANUAL:
TITLE: Clinical Services Fi SUBJECT: Clinic fees	nancial & Operatio	ns Guidelir	es	
Effective (date): 10/10	Replaces (date	date): Renewal due (date):		Page: 1 of: 6
Originated by: Veronica Shaw, Ke	llie von Volkli, Jes	sica Syska	Approved by:	Jean Baldwin

Jefferson County Public Health (JCPH) **Clinical Services Financial Guidelines**

Jefferson County Public Health Mission:

To provide quality, timely and responsive clinical services to the residents of Jefferson County, in the most cost effective manner.

Goal: The Department will provide high quality health care and public health services. All clients will be treated equally and in a consistent manner, regardless of ability to pay or service being received. In all instances, the client's confidentiality and safety will be considered.

The following Financial Guidelines are established in support of the above and apply to clinical services. Fees will be collected following the most recent County ordinance (see Attachment A).

- I. Fee Setting: Income given by the client is accepted as stated. Proof of income may be requested for clarification.
 - Office visit fees are calculated and reviewed annually, and are based on a cost analysis. In the event the cost analysis does not have an established rate, fees will be based on contracted insurance provider rates, Medicaid rates, or market rates.
 - B. Fees for medication, external laboratory services and FP supplies are based on a cost analysis. In the event the cost analysis does not have an established rate, fees will be actual costs rounded to the next dollar.

II. Charges for Services:

- A. The sliding scale is available for all clients but not for all services.
- B. Charges will be determined on a sliding fee scale (Attachment B). This sliding fee scale is based on Federal Poverty Guidelines and are updated annually. The sliding fee schedule used will set the minimum pay category at 0-100% and full pay at 251% of the Federal Poverty Guidelines, offering up to a 100% discount.

III. Fee Assessments:

- A. Fee Assessments will be conducted during each client registration/check in process. Generally it is conducted every visit or when requested by the client or deemed necessary by staff.
- B. A uniform method of financial screening will determine the client's ability to pay.
- C. The client's ability to pay for services received is based upon gross monthly or annual income and the number of persons in the family. If the client has seasonal employment, annual income may be used.
 - Sliding fee scale is for immunizations, communicable disease, family planning, HIV, STD and foot care.
- D. The following clients are not eligible for a sliding fee discount:
 - 1. Travelers clinic visit fee and vaccines (see CD manager with questions)
 - 2. Clients who refuse to provide income and family size information.
 - Clients who have received insurance payments for services rendered and have not made payment to JCPH.
 - 4. Clients who request services that are not recommended by a clinic practitioner.
 - Adult clients, who refuse to permit billing to third party resources or refuse to sign the HCFA 1500 (standard billing claim form) release of information and assignment of benefits statements.
- E. Chief Operations Director and the Community Health Public Health Manager have the authority to waive fees for individuals who for good cause are unable to pay but do not qualify for the Sliding Fee Schedule. Clinical Staff may submit request verbally or in writing to management with reason for waiving fee. Management will date and sign on encounter "no charge" list "good cause". Reason will be written in confidential client chart. (for FP audit)

IV. Assessment Guidelines:

A. Family Planning/STD Clinics (see FP Title X Manual)

- All requirements in the Washington State Department of Health/Family Planning Program Policy 4500 on Client Fees, Billing, and Collection will be followed for all Family Planning clients.
- 2. Adolescent Clients (18 Years and Under):
 - Any client 18 years and under is considered an adolescent and may be assessed either as a member of their family or as a separate family.

2

- b. If the client is supported by a parent and the parent is willing to pay for the visit, the client should be assessed as a member of the parent's family and the family's income should be used to determine the fee category.
 - If a client's confidentiality could be violated by the requirement to produce information regarding family income, JCPH will assess the client's ability to pay
 - The client will be considered a family of "one".
 - Add personal income from allowance or employment. Income is based solely on the disposable income available to the client. (Do not use income from a partner, parent, aunt, uncle or friend) to compute total family income.
- 3. Adult Clients (19 Years and Older):
 - a. Use the client's income and family size to determine the fee category.
 - b. A married couple is one family- 2people.
 - A single adult living alone, or with a person or persons not related by marriage, is a separate family.
 - An adult child living with parents is a separate family

B. Immunization Services

To assess income for immunization clients consider type of vaccine to be received before assigning fees. (Travelers do not qualify for sliding scale.) Generally, the review is routine but exceptions may evolve, requiring KIPHS to track the vaccine source. (Attachment C1)

- 1 Routine immunization services
- 2. Travelers clinic visits
 - a. State supplied Vaccine
 - b. Private supplied vaccine
 - 1a. everything slides
 - 2a. only the vaccine slides and not the visit
 - 1b. only the visit fee slides
 - 2b. nothing slides

FAQs exceptions:

- i.e. adolescent who gets both State and private supply vaccines on the same visits.
- i.e. Travelers who are children will receive State supplied vaccine and private
- i.e. 19 yr olds may get State supplied HepB and MMR is available to all college students born after 1957.

ANSWER:

Follow source of vaccine, It is the RNs call which vaccines clients get.

Assessing fees:

Adolescent Clients (Under 18 Years of Age)

a. Family income and size will be used to determine appropriate fee category

Adult Clients (19 Years and Older):

- a. If the client is supported by a parent and the parent is responsible for the client's medical care, the client will be assessed as a member of the parent's family.
- If the client does not live with a parent or is otherwise self supporting, the client's income and family size will be used to determine the fee category.

V. Payment:

A. Insurance co-pays are due at the time of service.

Only exception to this policy is clients who qualify for Title X Family Planning Services. Fees charged to these clients will be assessed based on household/size and income.

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For Title x family Planning Services:

If the insure plan is billed the client waits for the insurance response before billing the client for the service. The clinic does not collect insurance plan co-pays at the time of visit. If the insurance pays the amount in full the client will not be billed. If the insurance payer does not pay the full charge clients may be asked to pay up to the amount they would have been charged on a sliding fee schedule once the insurance payment is posted to the account. (for FP Audit)

- B. Payment upon receipt of services is expected. If the client cannot pay for services on the date received, a bill will be sent to the client with payment expected in 30 days from the date of service. Payment arrangements can be made in advance during the fee assessment process or by contacting the patient accounting staff.
- C. Statements of outstanding balances are mailed on a monthly basis requesting payment. In the case of clients who do not wish to have statements sent to their residence, for reasons of confidentiality, it is the responsibility of the client to notify billing staff not to send bills. Monthly bills are not mailed to confidential family planning clients. For adult clients requesting that no statements be mailed for reasons other than being a confidential teen or family planning client, payment will be requested at the time of service. Accounts determined to be delinquent will be processed by following the "Delinquent Account" policy (attachment).
- D. Employer paid services will be provided at the full fee for service and be billed to the employer or their 3rd party payer.
- E. If, because of anticipated non-payment by a third party payor and/or inability of a client to pay for services, the client is reluctant, postpones, or chooses not to receive services, a call will be made to a supervisor.

VI. Medical Coupons/Medicare (DSHS)

- A. DSHS Medical coverage is accepted as payment in full for all covered services.
- B. Clients will be expected to provide their medical card or Medicare card at the time of service. Staff can access PIC #s and check eligibility on line.

VII. Third Party Billing (Insurance)

A. Health Insurance

For clients with health insurance, the full amount of the charges will be billed to the client and insurance company on behalf of the client. Once the insurance pays JCPH or denies the charges, the sliding fee scale will be applied to the balance for services and clients that qualify, and will be reflected on the client's next mailed statement.

B. Insurance and Confidentiality

- 1. In situations where a client is age 18 or younger and their parents are not aware that they are seeking JCPH services, to protect the client's confidentiality, insurance will not be billed and the sliding fee scale will be applied. And if applicable, the client may apply for Take Charge.
- 2. If a client, over age 18, who has health insurance, requests we not bill them due to confidentiality or safety, we will respect their request and will apply the sliding fee scale. However, payment will be due at the time of service.

C. Insurance Co-Pays

In accordance with contractual agreements with insurance companies, we will collect from the client the required co-payment at the time of service. If the client is unable to pay, or has not provided their insurance information, at the time of service, we will bill them for the co-payment amount.

VII. Other Non-Routine Service Provision

A. Offsite Clinics:

In place of an office call charge, an hourly rate for the provider will be charged in addition to the fee for the service. The hourly rate will be evaluated based on public health costs and priorities and set by the clinical supervisor and Department Head.

B. Employer Paid In-House Services

C. Non County employer paid adult immunizations are referred to Immunization Coordinator to determine if other community providers are able to provide service or to schedule internal clinic. Exception ongoing: Workers from Animal Services, local police and local fire districts.

D. Individual Based Special Clinics (i.e. MMR clinics): Charges for services will be determined by the Immunization Coordinator, Department Head, and supervisor scheduling special clinics.

IX. Referrals for Outside Services/Prescription Medications

A. Outside Services

- When clients who have a third party payor are referred to an outside service (such as xray or lab), the outside service will be instructed to bill that third party payor. The client will not be billed on JCPH's encounter form for that service.
- When clients who do not have a third party payor are referred for chest xrays to rule out active tuberculosis, the xray provider will be instructed to bill JCPH for services. The client will be billed on JCPH's encounter form for the chest xray and the sliding fee scale will be applied (unless the client is a sponsored immigrant)

B. Prescription Medications

- Clients with third party insurance requiring prescribed medications, those
 medications will be obtained from a local pharmacy under JCPH staff's prescriptive
 authority, unless it is determined that obtaining the medications from a pharmacy will
 pose a barrier to that client obtaining the medications.
- Clients who do not have a third party payor requiring prescribed medications, JCPH will dispense the medications and the client will be billed on JCPH's encounter form for the medication and the sliding fee scale will not be applied (except for treatment of a communicable disease or FP method).
- Screening and treatment of some communicable diseases (TB, STD) are mandated services for JCPH. A visit fee and the cost of medication will be billed for private insurance and Medicaid, but may be waived by the Communicable Disease Coordinator, Department Head or Supervisor.

X. Exceptions

Exceptions can be made to these guidelines in order to prevent creating a barrier to receiving services, or for a documented public health necessity. All exceptions made to these guidelines *must* be authorized by the JCPH Director *in writing*.

D. JCPH Community Health Fees



Department: Jefferson County Public Health		Public Health Division: Community Health		Section of Procedure Manual Fees	
Title: Community Health	Fees		3 ===		
Subject: Policy for setting (Community Health fe	ees			
Effective (date): 01/11	Replaces (date):			Page: 1 of: 1	
Originated by: Jean Baldwin			Approved by:	Jean Baldwin	

Community Health Fees

Fees

All of the services/fees listed for Jefferson County Public Health Community Health are set as follows:

A cost analysis will be completed annually to set reimbursement rates for Community Health including family planning services, birth control methods and immunizations.

Fees for medications, antibiotics and treatment methods will be based on cost of acquisition unless acquired by an outside vendor at no cost to Jefferson County Public Health. No handling fee to cover staff time on inventory and ordering will be assessed.

All fees for vaccines not subsidized by the Vaccine for Children or Washington Vaccine Association will be based on the cost of the vaccine, shipping and handling, and allowable market reimbursement

Laboratory Services are based on the actual fees of laboratory contractors, price lists are available upon requests.

Office visit fees are calculated and reviewed annually, and are based on a cost analysis. In the event the cost analysis does not have an established rate, fees will be based on contracted insurance provider rates, Medicaid rates, or market rates.

The Clinical Services Financial and Operations Guidelines policy is in place, reviewed and updated annually, using the Federal Poverty Guidelines to establish the sliding fee schedule. A copy of the stiding fee schedule will be available upon request.

The sliding fee schedule will not be available or offered for privately purchased vaccines administered

Certain service fees may be waived, including but not limited to communicable disease prevention services, medications, laboratory services or vaccines to prevent outbreaks of communicable disease. Services for vaccines subsidized by the Vaccines for Children of WA Vaccine Association and Family Planning Services will not be denied due to a client's inability to pay.

Jefferson County Public Health will automatically implement future modifications to fees for vaccines, medications, and medical supplies when any of the following changes occur:

1. There is a change in the actual cost of the service provided by an outside vendor, the supply,

- medication, vaccine, laboratory charges, or shipping and handling costs.

 2. A new Federal Poverty Level Guidelines change.

 3. The maximum allowable Medicald reimbursement rate changes.

Fees for Vital Records are set by the RCW 70.58.107. The cost sheet is available by request,



E. Spokane Health District Fee Policy

BEFORE THE BOARD OF HEALTH OF THE SPOKANE REGIONAL HEALTH DISTRICT

RESOLUTION #11-02

HEALTH DISTRICT FEE POLICY

WHEREAS, the Spokane Regional Health District Board of Health has determined that fees for certain services are necessary to augment and maximize public funds for public health functions to protect the citizens of Spokane County, and

WHEREAS, RCW 70.05,060 provides that the Board shall "Establish fee schedules for issuing or renewing licenses or permits or for such other services as are authorized by law and the rules and regulations of the State Board of Health: Provided, That such fees for services shall not exceed the actual cost of providing any such services."

NOW, THEREFORE, be it resolved that fees for services provided by Spokane Regional Health District (the District) shall be determined annually as follows:

SECTION 1. DETERMINATION AND COLLECTION OF FEES

- A. Fees for any District service shall be based on the total cost of providing the service, including the proportionate share of all indirect costs. It is understood that "indirect costs," as used in this resolution, include Division "program support," and District overhead consistent with the District's approved indirect cost allocation plan. Although the District may strive for 100% cost recovery, it is recognized that because the District cannot make a profit (100% + recovery) the goal is to work towards 100% recovery.
- B. It is recognized that some of the District Services are not fully supported by fees, and 100% cost recovery by fees may not be feasible to protect the public's health at the total cost of the service.
- C. The Health Officer or designee has the authority to waive or change any fee for the benefit of the public's health. Any proposed changes to the approved fee schedule require written approval from the Health Officer or designee.
- D. A discount schedule based on the most recent federal poverty guidelines for family size and income may be applied to some clinic fees. The discount schedule shall range from 33% to 67% of full fee. Persons/families below 150% of poverty shall pay 33% of full fee, persons families between 151 % and 200% of poverty shall pay 67% of full fee and persons above 200% of poverty shall pay full fee. The District shall use one or more means tests to verify eligibility for discounted fees. Income verification such as pay stubs or tax returns must be provided at the time of service and will be valid for one year. Clients that have no source of income verification will be asked to submit a signed self declared statement

Health District Fee Policy

Resolution #11-02 - Effective January 1, 2012.

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outlining family income and size. Income verification must be provided at the next service. Those who do not subsequently submit income verification will be charged full fees.

- E. Where appropriate, an hourly rate will be established in the fee schedule to recover 100% of the estimated total cost to provide services. The hourly rate will be based on the average hourly employee cost to include benefits, indirects and other direct program costs.
- F. New fees not previously established will be based on 100% of the estimated cost of providing the service and adjusted after the actual cost has been determined. The Health Officer, or designee, can direct an alternate cost recovery percentage on an individual basis.
- G. At the discretion of the Health Officer, or designee, the District may enter into contracts with public or private employers to provide a volume of specific services for a designated period of time at a negotiated fee.
- H. In discrete circumstances, the District may use a professional services collection agency. Referral of an account to a collection agency shall require the prior written approval of the Administrator or designee.

SECTION 2. PERIODIC REVIEW

The agency fee schedule shall be reviewed periodically and revised in accordance with this resolution. Cost studies of services and products included in the fee schedule shall be conducted on a periodic basis. The periodic review shall include revision of the discount schedule according to the most recent federal poverty guidelines. The proposed fee schedule revision shall be presented for consideration by the Board at the June, July or August Board of Health meeting. This mid-year fee schedule revision shall be used to estimate program revenues for the next budget year and shall be implemented January 1 of the following year.

SECTION 3. PAYMENT FOR PUBLIC HEALTH SERVICES

A. The Board recognizes that some public health services and functions are offered as community health protection and are not appropriately supported entirely by fees and may have a cost recovery rate through fees based on less than 100% of cost.

In order to adequately protect the public health of the community, Spokane Regional Health District must ensure availability of treatment services for certain communicable diseases. If the minimum fee for service cannot be collected or proves to be a hindrance to continued treatment, the customer or the family of the

Health District Fee Policy Resolution #11-02 - Effective January 1, 2012

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customer may request or be offered a payment plan or a write off. Write off determinations require the documented approval of Program Manager or designee.

Decisions to provide treatment services to clients with outstanding balances will be based on medical judgment of the Health Officer or designee.

- B. The District may bill full fee to all potential third party payers. Any reimbursement from a public insurer (Medicare, Medicaid, etc.) shall be considered payment in full. Customers with private insurance will be expected to pay in full at the time of service and are provided a receipt with required information to get reimbursed from their carrier.
- C. The District recognizes that it is most efficient to collect all clinic fees at the time services are provided. The District will expect and pursue fee collection for clinic services with a minimum payment at the time of service of \$10.00. However, if fee collection on the date of service is not possible, customers shall receive statements for six months before referral to a professional services collection agency is considered. Customers who request participation in a payment plan will be billed monthly until the balance is paid in full. The minimum billing on a payment plan is \$25.00, unless the customer has made special arrangements.
- D. The Board recognizes that some services are partially funded by grants that may limit the District from charging full fees.
- E. From time to time, the District is responsible for epidemiological investigation of exposures or outbreaks transmitted from a business employee to their public customers and prophylaxis of potentially exposed individuals. The Health District will pursue payment from the identified employers.
- F. Except for variable fees based upon hourly rates, fixed Environmental Public Health fees shall be collected prior to the performance of service or at the time of service. Fees based upon hourly rates shall be invoiced upon determination of the actual time associated with providing the service(s).

Health District Fee Policy

Resolution #11-02 - Effective January 1, 2012.

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DATED this	day of	,20
SPOKANE REGI BOARD OF HEA	ONAL HEALTH LTH	DISTRICT
Board Chair		Board Member
Board Member		Board Member

Health District Fee Policy Resolution #11-02 - Effective January † 2012

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F. JCPH Traveler Adult Fee



Department: Jefferson County P			Health/ Nursing	Section of Procedure Manual Immunizations
Title: Traveler/ Adult V	accine Fee			2
Subject: Fee guidelines for	Traveler Cons	sultation appo	intment with nu	rse
Effective (date): 06/11	Replaces (d 03/08	ate): Renew 06/1	wal due (date): 2	Page: 1 of: 1
Originated by: Jane Kurata			Approved by:	Jean Baldwin

Traveler/ Adult Vaccine Fee

Any traveler who has a nurse appointment will be charged a visit fee for the travel consultation, including a traveler who either decides not to get vaccines that day and plans to come back for them, or turns out to be up-to-date on all vaccines, but still received all of the handouts and malaria prevention information, etc. A fee is assessed regardless of whether vaccines are administered, to compensate for the time and skills used to complete research, review the recommendations, and review the immunization records.

This policy should begin with the support staff telling every client, when they make an appointment, that the travel consultation fee is \$60 for the first person and \$35 for additional household members seen at the same visit. The vaccine and administration fees are added to

It would be helpful if clients are informed when they call, that detailed travel recommendations are covered in the visit and that phone consultation is limited.

- If the visit is a consultation only and no vaccines are given, the fee is as above. If the client returns for another travel appointment to receive immunizations only, with no additional consultation needed, the visit fee is \$38.
- · Travelers with return appointments for follow-up doses in a vaccine series, requiring no additional consultation, will be charged according to the walk-in immunization clinic fee schedule.
- · Clients seen in walk-in immunization clinic who receive some travel immunizations may be charged \$38 if a limited travel consultation is done by the nurse. Normally no travel consultations will be done in walk-in clinic as time does not allow for this.

Immigrants and other families needing extensive review of their immunization records will be scheduled into a travel appointment. No fee is charged for records review. Any immunizations administered will be in the Walk-in Immunization Clinic fee schedule.



G. BFPH Unclaimed Property

Benton-Franklin Health District

Policies and Procedures

Subject:	Policy: X Procedure: X	No: BFHD.01.16A.004
	Effective Date: 05/1999	Page 1 of 2
Administrative Approval:	Supersedes:	
Committee Approval/Review:	1	
Development Team/Author(s): Bonnie Ha	il .	
Audit Review By:	Bonnia Hall	
Date:	08/11	

Purpose -

The purpose of this policy is to provide instruction to Benton Franklin Health District (BFHD) Billing department and Administration staff on reporting unclaimed property to the Washington State Department of Revenue in accordance with RCW 63.29.130.

Revision History

This is the first version of the policy/procedure in this format. Policy originally was established in 1998.

Persons Affected -

Benton Franklin Health District Billing Department and Administration staff.

Policy

Property held by the Benton Franklin Health District that remains unclaimed by the owner for more than two years after becoming payable or distributable is presumed abandoned and will be turned over to the Washington State Department of Revenue in accordance with RCW 63,29 130.

An unclaimed property report will be filed each year by November 1[™] as required by RCW 63,29.170. Written notice will be given to the apparent owner for unclaimed property valued at \$75.00 or greater between May 1[™] and August 1[™]. Filing of annual reports may be done electronically through the website at www.ucp.dor.wa.gov or by mail.

Definitions

Any tangible or intangible property that is unclaimed by its rightful owner after a significant period of time.

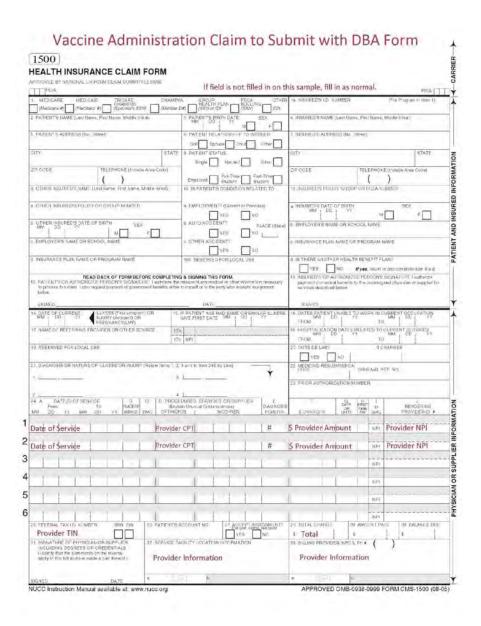
Responsibilities

- Locate and prepare accounts
- Attempt to returned unclaimed property to rightful owner.
- Prepare unclaimed property filing
- Submit filing to Washington State Department of Revenue, unclaimed property division along with any monies owed.

Procedures -

- 1. In Magic, print Credit Balance Report, found under Reports/Billing/General.
- 2. Review each account to determine the date of last contact or activity. Any account with a credit balance 2 years or older should be prepared to turn over to Department of Revenue.
- 3. If a Credit Balance letter has not yet been sent to the client, and there is no mail return noted on the account, send out a letter before reporting and turning over to the state. This can be done in Magic by going to Reports/Clients/Batch letters & forms. Select either "Refund" letter or "Smcredit" letter for small balance credits. Note on the account when the letter was sent. Follow up in 30 days.
- 4. If the date of last activity (charge, payment or note) is 2 years or greater the credit balance must be turned over to the Washington State Unclaimed Property division. See table entitled Report Year Conversion Table in the Unclaimed Property file.
- 5. Gather any outstanding (uncashed) warrants from Accounts Payable that are 2 years or
-). Log onto Washington state unclaimed property website at www.ucp.dor.wa.gov and click on "report unclaimed property"
- 2. Complete a Detail Report at the website for each client, including any uncashed warrants.
 - 6. Completed a Summary Report. (see prior year's in unclaimed property folder as samples):
 - 7. Complete a refund request for Washington State unclaimed property for the entire amount to be turned over and include with the detail & summary reports.
 - 8. Note what action was taken in Magic accounts for clients with credit balances being

H. DBA Sample Forms



1500 HEALTH INSURANCE CLAIM	Sample DBA	Form	
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I. JCPH Immune Globulin After HEP A



Department: Jefferson County Public Health		Division: Community	Health/Nursing	Section of Procedure Manual: Immunizations		
Title: Immune Globulin A	After Exposure	to Hepatitis	A, Hepatitis NANE	3, Measles and Rubella		
Subject: Policy for dispensi	ng Immune Gl	obulin for com	munity cases & c	determination of dosage		
Effective (date): 06/11	Replaces (d 06/09	late): Rene 06/13		3		
Originated by: Lis	a McKenzie		The second second second second	Dr. Tom Locke		

Immune Globulin after Exposure to Hepatitis A, Measles and Rubella

Immune Globulin is given only after consultation with the Communicable Disease Program Coordinator or Health Officer. This policy is intended for community cases and to determine proper dose.

IG prophylaxis for contacts may be considered. Contact the Health Officer.

Contacts in their first trimester of pregnancy may be considered for prophylaxis with IG. Contact the Health Officer.

HEPATITIS A:

Prophylaxis is recommended within 2 weeks for household contacts or other persons with significant opportunity for fecal-oral exposure to a diagnosed case of Hepatitis A. A CD nurse will determine if true exposure has occurred, see ACIP for discussion. The CD nurse will notify the clinic where the client is being seen or is to be seen.

For healthy persons aged 12 months - 40 years, single-antigen Hepatitis A vaccine is preferred over IG. For persons aged >40 years, IG is preferred, vaccine can be used if IG is not available. IG should be used for children <12 months, immunocompromised persons, persons who have had chronic liver disease diagnosed, and persons for whom vaccine is contraindicated. See ACIP for details.

Dosage of IG Prophylaxis for Hepatitis A 0.02 ml/kg: 1 Kg - 2.2 lbs

Weight	Kilograms	Dosage		
1 - 50 lbs.	0 - 22.7	0.5 cc		
51 - 100 lbs.	23.2 - 45.5	1.0 cc		
101 - 225 lbs.	45.9 - 102.3	2.0 cc		
226 - 275 lbs.	102.7 - 125	2.5 cc		
276 - 325 lbs.	125.5 - 147.7	3.0 cc		
326 - 375 lbs.	148.2 - 170.5	3.5 cc		



J. Kinship Caregiver Declaration



Department: Jefferson County Pu		sion: nmunity Health/ Nursing	Section of Procedure Manual Clinic/Medical Records
Title: Kinship Caregiver's	Declaration of Res	ponsibility for a Minor's H	lealth Care
			e not their legal guardians may
	are of a child in the	,	Page 1 of 1
Effective (date): 06/11	Replaces (date): 01/09	,	Page: 1 of: 1

Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care

- 1. Copies of the "Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care" and an explanatory brochure will be kept at the reception desk, and in a folder in the lower drawer of the immunization room desk. Masters will be put in the notebook by the back copier.
- 2. Any staff who realizes that an adult accompanying a child for services is a kinship caregiver should ask them to complete the "Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care" form.
- 3. The original should be stapled and filed with the Vaccine Administration Record.
- 4. Medical records staff will make a notation of the existence of the form and its expiration date in KIPHS client document tracker.
- 5. A copy of the "Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care" form should be kept in medical records until it expires. If the client returns during the 6 month period that the form is valid, another copy should be made and stapled to the Vaccine Administration Record for the new visit.
- 6. Six months after the "Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care" is signed, the copy on file can be shredded.
- 7. If the client returns after the 6 month period, the caregiver should complete a new "Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care" form.



K. Spokane Write Off Policy

Policy No.: Page No.: 1 of 3 Effective: DRAFT



WRITE OFF POLICY

Subject Title: Write Off Policy for Delinquent and Uncollectible Accounts

Spokane Regional Health District shall collect all revenues in accordance with acceptable billing, collection and auditing standards.

All open receivable accounts with delinquent payment activity will be handled in a timely and effective manner to ensure maximum revenue collection.

The purpose of this policy is to provide internal guidelines for handling delinquent and/or uncollectible receivable accounts.

Scope:

This policy applies to those workforce members who are responsible for the collection of delinquent and/or write off of uncollectible debts. Collection areas exist within all divisions of the Health District.

Delinquent/Uncollectible Accounts:

Individual Client Accounts: Any client service account that has received statements for four consecutive months after the date of service and has had no activity of service, payment or inquiry to settle the debt will be considered delinquent or uncollectible.

Other Receivable Accounts: Accounts that are 120 days past due and have had no activity of payment or arrangement of payment to settle the debt will be considered delinquent or uncollectible.

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Policy No. Page No.: 2 of 3 Effective: DRAFT

Process for collection of delinquent debt will include as many of the following as appropriate:

- · Consecutive monthly billings;
- Telephone contact or documented attempted telephone contact of contractors grantors, or businesses regarding past due account, and for non-confidential clients as appropriate;
- Follow-up billings with all third party payers;
- Follow-up letter, memo or collection request;
- · One-on-one contact with owner of delinquent account;
- Referral to professional service collection agency;
- Providing ongoing services must be made with consideration of outstanding debt by division director or designee.

Collection Referral:

In discrete circumstances, the Health District may use a professional service collection agency.

- Written approval of the administrator or his/her designee (i.e., appropriate division director) and the comptroller is required prior to referring an account to a professional service collection agency or for seeking redress through the court system.
- All documentation pertaining to billing and attempts made to collect the debt will be made available for the review and approval process.
- Any fee that is charged for a collection service will be charged back to the division and/or program.

Write Off Criteria:

- Private pay for direct service accounts that have received statements per the
 process for collection of delinquent debt and for which there has been no activity
 of service, payment or inquiry to settle the debt, will be written off 12 months
 after the date of service.
- Medicare/Medicaid or L & I accounts that have <u>not</u> been billed according to third party policy and procedure.
- The difference between the full fee for service and contracted assignment of payment.
- If the minimum fee for services proves to be a hindrance to continue treatment, the client or family of the client may request a write off.
- Where the debt has been discharged in a bankruptey and there is no guarantor or successor.
- Where the debt is disputed and the Health District has insufficient documentation to pursue collection efforts,
- · Where the debtor has died and there is no guarantor or successor.
- Where the amount of debt is insufficient to justify collection efforts.
- Where the debtor has no assets and no expectation of having any in the future.

NOTE: Documentation must be provided for review and approval by the appropriate division director and the comptroller prior to actual write off of account(s).

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Policy No. Page No.: 3 of 3 Effective: DRAFT

Review and Approval:

The client services supervisor responsible for billing and collection of delinquent and/or uncollectible debt will provide the appropriate division director with all documentation to review and approve the write off procedure for their program. The division director will then forward all information to the comptroller for final approval. Actual write off(s) will be done by the comptroller or designee.

Any accounts over \$500 will be reviewed and approved by the administrator and/or health officer. The administrator and/or health officer will review the submitted information to ensure that cost-effective methods to collect the debt do not exist.

The information provided for the review and approval process should include, but not be limited to:

- · Name of debtor
- Type of debt
- Amount of debt
- Date of service
- Reason for write off
- Documentation of collection procedure to validate write off
- Program/division name
- BAC code
- Division director/comptroller signature

Write Off Entry:

After administrative approval the comptroller or designee enters the write off information into the Health District's receivable system while maintaining appropriate backup. The entry should include the following information:

- Program ,Project and type of funds
- · Amount of the write off

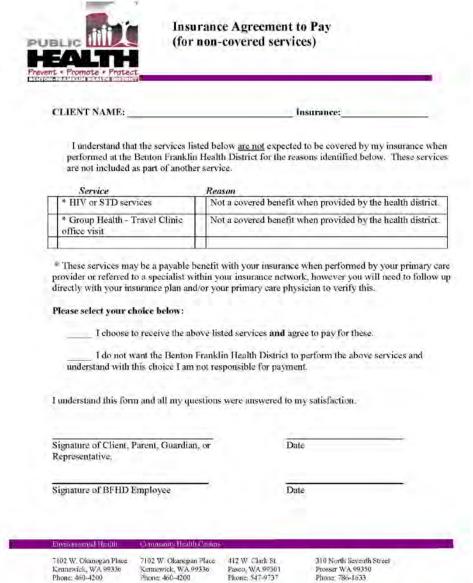
If payment is received after the write off has occurred, contact the comptroller or finance supervisor for instructions on how to apply the payment.

- This policy will be reviewed every 3 years or when significant changes are needed- whichever come first.
- This policy is to be reviewed by comptroller and submitted to the administrator for approval.
- Notice of updates will be distributed to management team.

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L. Agreement to Pay Form – Benton Franklin





M. Client Registration Form

		Appt Date / Day Time For Office Use Only Chart #
Client Registration F	orm	
1. CLIENT INFORMATION:		
		Middle Initial
Social Security Number	Birth Date	//Age
Mailing Address: Street/PO Box		Apartment Number
City	State Zip Code	County
Date moved to this County	How long at current ad-	dress?
Phone Number ()	☐ Home ☐ Wor	k
Have you bean in before? ☐ Yes ☐ N	lo If yes, when? Fo	r what service?
If you were seen under a different name	, what was it?	
2. PERSONAL INFORMATION (Fo	or statistical purposes only):	
Gender: Male Female	Single parent of childre	n under 18?
Marital Status: ☐ Married ☐ Divorce	d Widowed Separated	□ Never Married □ Living with Partner
Race: Caucasian/White Af	rican American/Black	☐ Native Hawaiiar/Other Pacific Islander
☐ American Indian or Alaska	Native Other	and the second s
Ethnicity: Latino Hispanic		
Language(s) Spoken		Last grade completed?
Employment Status: Employed for	wages Self-employed	Homemaker Student Retired
☐ Out of work for more than t	year Out of work for less	than 1 year Unable to work
Disability Status No Disability	☐ Short term ☐ Long term	☐ Permanent/Total
Do you have a regular health care provi	der? ☐ Yes ☐ No When I	last seen?
Would you say that in general your heal	th is excellent, very good, good, fa	if, or poor?
3. PARENT/GUARANTOR INFO (p.	erson responsible for payment i	f other than the client listed above):
If services are to be billed to your emplo	yer please attach a billing authoriz	ration letter
		Middle Initial
Social Security Number		Relationship to Client
Street Address		Apartment Number
City		Zip Code
Phone Number ()	☐ Home ☐ Wor	k 🗆 Cell 🗆 Message
4. FEE/PAYMENT INFORMATION	L	
Medicaid coverage? ☐ Yes ☐ No	Medicare coverage? ☐ Yes ☐	No Private insurance? ☐ Yes ☐ No
Other insurance (please list for statistical purp	poses only):	
YOU MUST SHOW US YOUR	MEDICAID AND/OR MEDICARE CAP	RD EVERY TIME YOU CHECK IN
income level. In order to be eligible for a your inco	iscounted fees you must provide the me (i.e. pay stub, tax return, signed	
Total (Gross) Household income, includ	A STATE OF THE STA	Security of the second
\$ pe	r □ Year □ Month □ Wee	ek 🛘 Hour(s per week?)

How many family members live at this address and/or are supported by this income?



N. Credentialing Information Sheet

	NCY INFORMATION		
Age	ncy Name:		
Tax	ID#:	NPI#:_	
Phy	sical Address:		
Mai	ling Address:		
Prin	nary Specialty/Taxonomy#		
Inst	rance Information:		
1.	Carrier:	Policy#	Exp Date;
	Amount Per Occurrence:	<u> </u>	
2.	Carrier:	Policy#	Exp Date:
	Amount Per Occurrence:	5	
3.	Carrier:	Policy#	Exp Date:
	Amount Per Occurrence:		
HEA	LTH OFFICER INFORMATION		
Phy	sician's Full Name:		
DOI	WA MI) License #	Expiration Date
NPI		DEAM	
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DOB:	WA License#:	Expiration Date:
	Specialty/Taxonomy:	
Enrolled with cr	edentialing clearinghouse? List:	
Contracted priva	ately with insurance companies? List:	
1.00		
	Title:	
Staff Name and		
Staff Name and DOB:	Title:	_ Expiration Date:
Staff Name and DOB: NP#	Title:	_ Expiration Date:

O. Encounter Form – Jefferson

				HS Imm er Encounte	r Form	11-10	Pag			1
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Diagnosis	code	ID	First Na	ıme	Time	ID	First			Time
1)		1)0036 2)0006 3)0030 4) 5) 6)	CAROL JANE THOMAS			8) 9) 10) 11) 12) 13) 14)				
04/95 Rev	rision			Lab	work :	YES N	0			



P. Encounter Form - WallaWalla

	Adu POS STAN PINIST Mai	alia Walia County Health It Immunitation Encounter Form (TA) 5: 314 W Main, Walia Walia, WA 9936 II: PO Box 1753, Walia Walia, WA 993	(ID# 91-600138 2 62 Phone: 509.	н	Attack Encounter Label Pau Name DOB
Č.	Procedure	ADULT Service	ICD-9 Diagnosis	Fee	The second second
	Pa	rt 1: Office Visit/Administr	ation Fees		
	99211	1 (25) OV Single Imm	V05.9	25.00	
	99211	(25) OV Multi Imm	V06.9	25.00	
	99211	(TR) OV Single Imm	V05.9	50.00	
_	0.00	(TR) OV Single Intin	V06.9	50.00	
	99211	LATER CONTRACTOR CONTR	V00.9	30.00	
	99211	(TRFU)			
	90471	Imm Admin Fee 19		15.00	
	90472	Imm Admin Fee 2 nd		15.00	
	Par	t 2: Flu and Pneumonia Imr			
	90658	Flu Inactive	V04.81	12.00	
	90471	(FC) Flu Admin Fce	V03.82	18,00	dul
_	90732	Pneumonia	V03.82	27.00	
_	90471	(FC) Pneumonia Only Fee	V03.82	18.00	
_		(FC) Pricumonia W/Flu Fee	V03.82	18.00	100
_	90472	Part 3: Immunization		18.00	
-	90632	Hepatitis A	I V05.3	25.00	-
_	90632	Hepatitis B	V05.3	35.00	-
-	90649	HPV (Gardasil)	V05.8	150.00	
_	90713	IPV (Galdasii)	V04.0	30,00	
_	90735	Japanese Encephalitis	V05.0	1	
	90734	Meningococcal (Menactra)	V03.89	115:00	-
_	90733	Meningococcal (Menomune)	V03.89	115.00	
	90707	MMR	V06.4	55.00	- 1
	90690	Typhoid, Oral	V03.1	45.00	
	90691	Typhoid VI, Typhim	V03.1	55,00	
	90715	TDAP (Adacel)	V06.1	50,00	
	90714	TD	V06.5	25.00	
	90636	Twinrix (Hep A & B)	V05.3	50,00	
	90716	Varicella (Chickenpox)	V05.4	100,00	Provider Signature:
	90717	Yellow Fever	V04.4	90.00	Tromas, organization
	90736	Zoster (shingles)	V05.8	180.00	
	90675	Rabies IM	V04.5		
	90375	Rabies IG Amt mls	V07.2	*	
_		Im Globulin Amt: mls	V07.2	•	Office Use Only
		Part 4: Titers and Blood	Draw		
	36415	Blood Draw		10.00	DSHS Coupons7 V N
	86706	Hep B Surface Ab Titer	V77.99	23.00	8.0
	86735	Mumps, IgG Titer	V75.9	30.00	-
	86762	Rubella Titer	V73.3	22.00	-
	86765	Rubeola (Measles) Titer	V75.9	26.00	-
	86787	Varicella Titer	1 (2) (1 4 (4))	27.00	
_	Transactions	Part 5: Miscellaneous Ser	V07.9	No Fee	
	Malaria RX	Malaria RX given for Travel	V68.89	3.00	Encounter Entered
_	99429 (ICV)	International Certificate of Travel	V68,89	4.00	1.00
-	81025 99080	Pregnancy Test	V/2,4 V68.89	15.00	Amt Due
	IMCHECK	Imm Card Duplicate Imm Check Internal Records Only	V68.89	No Fee	Richtel
_	INCHECK	Part 6: Results Give		Lagree	Cash () Check [Credit Card]
-	Lungs			TAIn the	1
	MMRR: VARR	MMR Results Varicella Results	000	No Fee	Amt Paid



Walla Walla County Health Department Adult Immunization Encounter Form: 1 TAX 10# 91-6001381 POS: 314 Waln, Walla Walla, WA 99362 Mail: PO Box 1753, Walla Walla, WA 99362 Phone: 509.524.2650

ICD-9 Diagnosis CPT CHILD Services Procedu Part 1: Office Visit/Administration Fees 99211 (25) OV Single Imm 99211 (25) OV Multi Imm V06.9 25.00 V05.9 99211 (TR) OV Single Imm 50.00 (TR) OV Multi Imm V06.9 50.00 99211 90471 15.00 Imm Admin Fee 1" 90472 Jmm Admin Fee 2 15.00 Part 2: State Supplied Immunizations Admin Fee (Charges are Administration Feeds Only) 90702 0.0 15.00 90700 DTAP V06.1 0.0 15.00 DTAP, HEP B, IPV (Pediarix) 90723 V06.8 0.0 15.00 Flu 6-35 Months, PF V04.81 0.0 15.00 90655 Flu 3+ (5) PP V04.81 0.0 90656 90657 Fig 6-35 Months V04.81 0.0 15:00 90658 90633 90744 Fla 3+ (5) V04.81 0.0 15.00 V05.3 0.0 15,00 Hep A Hep B V05 3 0.0 15.00 90648 V03.81 0.0 HIB 90649 90713 HPV (Gardasil) V05.8 0.0 15.00 V04.0 0.0 1PV 15.00 90734 Meningococcal (Menacta) V03.89 0.0 V06.4 90707 MMR 0.0 90710 MMRV V068 0.0 15:00 90669 90732 V03.8. 15.00 Prevnar Pocumonia 0.0 Pneumonia 2-18yrs V03.80 0,0 15.00 90680 Rotovirus V05.8 0.0 15.00 90715 90714 90716 TDAP (Boostrix) V06.1 Td V06.5 0.0 15.00 Varicella (Chickenpox) V05.4 15.00. 90698 Part 3: Other Immunizations 90735 V05.0 Japanese Encephalitis 90.00 90717 Yellow Fever V04.4 V04.5 90675 Rabies IM Rabies IG Amt V07.2 V07.2 Part 4: Titers and Blood Draw 10.00 36415 Blood Draw 86706 86735 Hep B Surface Ab Titer V77.99 22.50 30.00 Mumps, IgG Titer V75.9 86762 22.00 Rubella Titer 86765 86787 26.00 27:00 Rubcola (Measles) Titer V75.9 Part 5: Miscellaneous Services Malaria RX given for Travel No Fee V68.89 3.00 99429 (ICV) International Certificate of Travel Pregnancy Test 4.00 Inun Card Duplicate
Inun Check Internal Records Only V68.89 15.00 V68.89 No Fee

Attach Engaunter Label Pat# Name DOB



Provider Signature:

Office Use Only
DSHS Coopone¹ Y: N
1010

07/22/2010 S./Administration/Policies, Procedures, Forms and Documents/Forms Personal Health/100722 SKR IMM ENCOUNTER CHILD & ADULT

No Fee No Fee

Part 6: Results Given

MMR Results Varicella Results

MMRR

VARR



WALLA WALLA COUNTY
HEALTH DEPARTMENT
PO Box 1753
Walla Walla, WA 99362
Phone 509.524,2650 • Fax 509.524,2678
DOWN-HEALTH WICK, AND PARTMENT OF THE PRINCIPLE OF

For Office Use Patient #: Registration date:

PLEASE PRINT

		Registration	Form		
Client information:					
Legal Name: (FIRST, MIDE	DLE, LASTY		Nick Nam	e?	Social Security Number
Street Address		City	State	Zip Code	Race (Please mark all that apply)
Mailing Address		City	State	Zip Code	American Indian Asian Black Hispanic White
Home Phone: ()		Work Phone:	()		Decline to Answer
Is this a contact numb	er? Y N	Cell Phone:	1 1		Ethnicity
BIRTHDATE: Mg/Da/Year	SEX:	Marital Status: S M	D Sep	Wid (Unkw)	☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer
If client is a dependen	t:				
Parent/Legal Guardian	Name: (FIRST, MIDDLE, L	AST)			Relationship Mother Father Foster Parent
Address Address		City	State	Zip Code	Grandparent Other
Home Phone: (Cell Phone: (Check One:	Parent 🗍	Legal Guardian	DATE
Work Phone: ()	SIGNATURE - BY:	SIGNING FOR	CLIENT YOU ASSUME FIN	ANCIAL RESPONSIBILITY
Emergency contact inf	formation:		In	surance information	n:
Name: (FIRST, MIDDLE, LAST Phone Number: (7)		D	o you have health in If YES: Do you have Medic	24.40.40
Information to help us	con/e vinitr			Do you have Medic	
Primary Language:	serve you.			Do you have Aetna	
Country Where Born:			1113	Do you have private	

Certification / Signature	
Assignment of Benefits: I authorization to Release Infortune extent necessary to validate mobilian medical insurance.	e information is true to the best of my knowledge. brize payment by my insurance directly to Walla Walla County Health Department mation: I authorize release of billing information to my insurance company only to y insurance claim. I understand that this billing may result in my future inability to
	e to pay for all Health Department clinic charges on the day of service. I given a copy of the Walla Walla County Health Department Notice of Privacy
SIGNATURE:CLIENT/PARENT OR LEGAL G	DATE:

S:\Administration\Policies, Procedures, Forms and Documents\Porms\Personal Health\Form Versions to Edit\100818 SKR Registration Form

Walla Walla County Public Health	ARTMENT 753 /A 99362						
Prevent - Promote - Protect	PERSONAL HEALTH, WIC, AND ADMINISTRATION:	Phone 509.524.2650 • Fax 509.524.2678 PERSONAL HEALTH, WIC. AND ADMINISTRATION: 314 W MAIN (ROSE STREET ENTRANCE ENVIRONMENTAL HEALTH: 310 W POPLAR, SUITE 110					
Patient Name:	Da	te of Bir	th:				
	How old is patien	TODAY	? _				
	NING FORM FOR ADULTS HILDREN AND TEENS	S, INF	ANTS	5,			
	f: Answering the following questions on is not clear, please ask the nurse to			er care to			
		Yes	No	Don't Know			
 Are you/child sick today? 							
Do you/child have allergies to r	nedications, food, or any vaccine?	-	-	_			
3. Have yourchild had a serious n	eaction to a vaccine in the past?		_	-			
 Do you/Does your child have/h ather immune system problem 	ad cancer, leukemia, HIV/AIDS or any ?	_	_	_			
 Do you/Does your child take co anticancer drugs, or had x-ray 	ortisone, prednisone, other steroids, or treatments?	_	-	_			
	red a transfusion of blood products, or bee re (gamma) globulin in the past year?	n	_	_			
Are you pregnant or is there a pregnant during the next month	chance you/your teen could become n?		_				
8. Have you/child received any va	accinations in the past 4 weeks?						
9. Did you bring your immunization	on record with you?	5					
MUST BE COMPLETED FOR C	LIENTS 18 YEARS OR YOUNGER:						
Is your child an American Indi Is your child enrolled in Medic Does your child have medical If YES, does your child's m	aid? YES NO	NO					
Form completed by:		Dal	e:				
	(For Clinic Use Only)						

Revised: 06/09
5' Policies, Procedures, Forms, and Documental Forms Personal Health/Cirnic Screening Tool for Everyone_090825.doc



VACCINE ADMINISTRATION REQUEST FORM Walla Walla Valla County Public Health

I have been given a copy and have read, or have find explained to me, the information in the "Vaccine Information Statemen/(s)" for the disease(s) and vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested.

Contract of the Contract of th	Middle Imbal	Lati Name	Date of Birth Age Today
Address	City	State	Zip Code Ser M
Phone	School		Race W H B A/PI AI
Please list any ALLERGIES to food or medicines.			DO YOU HAVE YES NO
Signature of person to receive vaccine or	person authorized to make request		Close Use Only Copy of Medicaid Card Attached? Yes No
X			Copy of Introduction Record? Yes No
ADULT SINGLE IMM	FOR OFFICE	CHILD SINGLE IMM	rama in a band
99211(25) OV V05.9	99211(25) OV V06,9	99211 (25) OV V05.9	99211 (25) OV V06.9
90471 Admin	90471 / 90472 Admin	(90471/90472 if needed)	(90471/90472 if needed)
REG [] TRAVEL [] TRAVEU []		REG [] TRAVEL [] TRAVEU []	REG [] TRAVEL [] TRAVEL [
iters	Other Services	THEOT I INVASCIT INVASO TI	Flu & Pneumonia
1 95705 Hep B SurfADE 1 HC Hep C Project] 99429 (ICV)	1 190471(FC) Flu OR Prieu Only
196735 Mamps [186762 Rubella		Malaria RX for Travel	[] 90472 (FC) Add if Flu&Pneu
1 86765Rubeola [1 86787Varicella		1 Traveler's Diambea RX	(use G0008 / G0009 w/Medican
1 99211(25) OV [136415 BDraw		1 D9999 Family Oral Health Ed	Total Canada Contra Hamiltonia
	of the following progra		INT, STO, or TB
DT Td DTap Tdap	POLIO	Measies Mumps Rubella	Hib
Dose Soc	Dose Scc	Doser Soc	Dose Scc.
Manuf and Lot K	Manuf. and Lot#	Manuf. and Lot #	Manuf and Lot#
Site of Injection: R 1 Arm Leg immunization and Dose # Given Today	Site of Injection: R L Arm Leg Immunization and Dose # Given Today	Side of Injection R. L. Arm Leg. Immunization and Dose # Given Today	Site of Injection: R L Arm Li Immunization and Dose # Given Today
1 2 3 4 5	1 2 3 4 5	1 2 3	1 2 3 4
Нор В	Hep A	Varicella	Prevnar
Dase ,5oc Manuf, and Lot #	Dose Scc Manuf and Lot#	Dose .5cc Manuf. and Lot#	Dose .5cc Manuf. and Lot #
	12-6-20-5	Aut. 00-21	
Site of Injection: R. L. Arm. Leg	Site of Injection: R L Arm Leg	Site of Injection: R. L. Arm Leg.	Site of Injection: R L Arm Le Immunization and Dose # Given Today
Immunization and Dose # Given Today Ped: Adult	Immunization and Dose # Given Today	Immunization and Dose # Given Today	Immunization and Dose # Given Today
1 2 3	Ped. Adult 1 2	1 2	1 2 3 4
Influenza	Twinnix	Typhim VI Oral Typhoid	Monomune Menactra
Dose Manuf and Lot #	Dose 5cc Manuf and Lot #	Dose Manuf, and Lot #	Dose Manuf, and Lot #
	manus and Lane	400000000000000000000000000000000000000	leight of a form
	Christiania B. I. Am		White the control of the same
Site of Injection: R L Arm Leg	Site of Injection R L Arm Immunization and Dose 9 Given Today	Site of Injection: R L Arm Immunization and Dose # Given Today	Site of Injection: R L Arm Le Immunization and Dose # Given Today
Site of Injection: R L Arm Leg	Site of Injection R L Arm Immunization and Dase 9 Given Today	Site of Injection: R L Arm Immunization and Dose # Given Today	Site of Injection: R L Arm Le Immunization and Dose # Given Today
Site of Injection: R L Arm Leg Immunitation and Dose # Given Today Yellow Fover	Immunization and Dose # Given Today 1 2 3 Gardasil	Pediarix (DTaP, IPV, Hop B)	Immunization and Dose # Given Today Pentacel (DTaP, IPV, Hib)
Site of Injection: R L Am Leg minuritation and Dose # Given Today Yellow Fever	Immunization and Dase 9 Given Today 1 2 3 Gardasil Dose Sco	Pediarix (DTaP, IPV, Hop B) Dose	Immunization and Dose # Given Today Pentacol (DTaP, IPV, Hib) Dose
Site of Injection. R. L. Arm. Leg minimunitation and Dose # Silven Today Yellow Fever Dose Manuf. and Ect #	Immunization and Dose # Given Today 1 2 3 Gardasil	Pediarix (DTaP, IPV, Hop B)	Immunization and Dose # Given Today Pentacel (DTaP, IPV, Hib)
Site of Injection: R L Arm Leg Immunization and Dose # Given Today Yellow Fever Dose Manuf and Ect # Site of Injection: R L Arm Leg	Immunization and Dase & Given Today 1 2 3 Gardasil Dose Soc Manuf. and Lot & Site of Injection: R. L. Arm	Pediarix (DTaP, IPV, Hep B) Dose Minut, and Lot # Size of Injection R L Arm	Pentacol (DTaP, IPV, Hib) Dose Manuf. and Lot #
Site of Injection: R L Arm Leg Immunization and Dose # Given Today Yellow Fever Dose Manuf and Ect # Site of Injection: R L Arm Leg	Immunization and Dase & Given Today 1 2 3 Gardasil Dose Sico Manuf. and Lot #	Pediarix (DTaP, IPV, Hep B) Dose Minut, and Lot R	Pentacol (DTaP, IPV, Hib) Dose Manuf. and Lot #
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Site of Injection: R L Arm Leg Immunization and Dose # Given Today Yellow Fever Vellow Fever Value and Let # Vellow Fever Value and Let # Vellow Fever Value Arm Leg Immunization and Dose # Given Today Zostavax Zostavax Jose Manual and Let #	Immunization and Dose 6 Given Today 1 2 3 Gardasil Dose Soc Manuti and Lot 8 Site sti Injection: R L Arm Investmization and Dose 8 Given Today 1 2 3 Pnoumovax Dose Manuti and Lot 9 Manuti and Lot 9	Pediatix (DTaP, IPV, Hop B) Dose Manut, and Lot # Size of Injection R I, Ann Immunication and Dose # Given Today 1 2 3 4 Dose Manuf, and Lot #	Pentacol (DTaP, IPV, Hib) Dose Menut and tod # Site of Injection R L Arm Le Immunization and Dose # Gisher Today 1 2 3 4 HEP C Project/Free Twinrix
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Site of Injection: R L Arm Leg Immunitation and Dose # Given Today Yellow Fever Manuf and Let # Site of Injection R L Arm Leg Immunitation and Dose # Given Today Zostavax Dose Manuf and Let # Site of Injection: R L Arm Leg Immunitation and Let # Site of Injection: R L Arm Leg Immunitation and Let # Site of Injection: R L Arm Leg Immunitation and Dose # Given Today	Immunization and Dose # Given Today 1 2 3 Gardasil Dose Soc Manuti and Lot # Site of Injection: R L Arm Inversimization and Dose # Given Today 7 2 3 Pnoumovax Dose Manuti and Lot # Site of Injection: R L Arm Leg Immunization and Dose # Given Today	Pediarix (DTaP, IPV, Hop B) Dose Memuf, and Lot # Site of Injection R L Arm Immunitation and Dose # Siven Today 1 2 3 4 Dose Dose Site of Injection: R L Arm Lose Site of Injection: R L Arm Lose Site of Injection: R L Arm	Immunization and Dose # Given Today Pentacol (DTaP, IPV, Hib) Dose Manufi and tot # Site of Injection R L Arm Le Inmunization and Dose # Given Today I 2 3 4 HEP C Project/Free Twinrix Dose Manufi and Lot # Site of Injection R L Arm Le Immunization and Dose # Given Today Grocery or Gas # Encounter Entered And Due Encounter Entered
Site of Injection: R L Arm Leg Immunization and Dose # Given Today Yellow Fever Dose Mand* and Ed # Site of Injection: R L Arm Leg Immunization and Dose # Given Today ZOSTAVAX Dose Site of Injection: R L Arm Leg Immunisation and Dose # Given Today	Immunization and Dose 6 Given Today 1 2 3 Gardasil Dose Soc Manuf, and Lot 8 Site of Injection: R L Arm Immunization and Dose a Given Today 1 2 3 Proumovax Dose Ste of Injection: R L Arm Leg Ste of Injection: R L Arm Leg	Pediarix (DTaP, IPV, Hop B) Dose Memuf, and Lot # Site of Injection R L Arm Immunitation and Dose # Siven Today 1 2 3 4 Dose Dose Site of Injection: R L Arm Lose Site of Injection: R L Arm Lose Site of Injection: R L Arm	Immunization and Dose # Given Today Pentacol (DTaP, IPV, Hib) Dose Menut and Lot # Site of Injection: R L Arm Le Immunization and Dose # Given Today 1 2 3 4 HEP C Project/Free Twinrix Dose Menut and Lot # Site of Injection: R L Arm Le Immunization and Dose # Given Today Grocery or Gas. Encounter Entered Amt Due Recopt #
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08/09/2010 S1/Administration/Policies, Procedures, Forms and Decuments/Forms/Personal Health/Form Versions to Ect/100809 SKR Vaccine Admin Request Form

CLINIC ENCOUNTER

1	CPT	Service	Diagnosis	Fee	Attach Encounter Label
	Procedure	THE RESERVE OF THE PARTY OF THE		- (Law Police	Name
多可		Part 1 ATB Visite	Photograph of the Control of the Con	25.00	DOB
	99211TB	(TB) Office Visit	V74.1	10.00	1
	86580	PPD	V74.1	No Fee	
	PPD-R	PPD Read Result:		No Fee	
	DupPPDRec	Duplicate PPD Results Given	V68.89		wa Walla Cou.
	T1020	Personal Care Initial Visit		No Fee	Walla Walla County Public Health
	T1020TS	Personal Care Follow up Visit		No Fee	Public Health
	TB ResRec	TB Treatment Record Original	V68.89	No Fee	AME
_	99080TRD	TB Treatment Record Duplicate	V68.89		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
_	TBRX	TH Meds Dispensed, P or LTB1	795.5	No Fee	WIJVE
-	TBRX	TB Meds Dispensed, Inf	0110	No Fee	Prevent - Promote - Protect
_	DOT Home	TB-DOT		No Fee	- Promote
_	DOT Office	TB DOT	-	No Fee	
_		Chest X-Ray	V74.1	60.00	SERVICE FACILITY Walla Walla County Tax ID# 91-6001381 POS: 314 W Main, V Mail: PO Box 1753, Phone: 509-524-288
	71010	Refer to St. Mary's - Chest X-Ray	V74.1	No Fee	SERVICE FACILITY L Walla Walla County H Tax ID# 91-5001381 Tax ID# 91-6001381 POS: 314 W Main, W Mail: PO Box 1753, W Phone: 509-524-2650
	REFXRAY	QuantiFERON Test	V74.1	71.00	SERVICE FACILITY LOCATION INFORMATION Walla Walla County Health Department Tax ID# 91-6001381 Tax ID# 91-6001381 Walla Walla, WA 99362 POS: 314 W Main, Walla Walla, WA 99362 Mail: PO Box 1753, Walla Walla WA 99362 Phone: 509-524-2650
	86480		V74,1	10.00	VICE FACILITY LOCATION INFOI Walla County Health Department D# 91-6001381 314 W Main, Walla Walla, WA 98 PO Box 1753, Walla Walla WA 98 e: 509-524-2650
_	36415	Blood Draw			0 B 4 9 1 1 1
2 1/2	张涛 35%	Part 2: STD Visits	policy Company	50.00	1 × × × 6 0 A
	99211STD	(STD) Office Visit	V74.5	No Fee	21×80 0
	STDFollow up	STD Follow Up	V74.5	No Fee	4.75 Br 7.5
	STDRes	STD Results	V/4.3	10.00	837 87
	54050	Destruction of Lesion, Male	-	No Fee	555 T
	54050INTNC	Destruction of Lesion, Male Initial w/OV	-	10.00	y Healt y Healt 31 Walla k, Walla
	56501	Destruction of Lesion, Female	-	10,00	Ha at C
	58501INTNC	Destruction of Lesion, Female Initial w/OV	-	No Fee	S = B
	87255	Herpes Test Culture - State Lab	-	-	Y LOCATION INFORMA Health Department 1 Walla Walla, WA 99362 Walla Walla WA 99362 50
	86695	Herpes Simples Antibody, Type I	1	58,00	a a D
	86696	Herpes Simplex, Antibody, Type II	-	10.00	artment WA 99362 WA 99362
	36415	Blood Draw	-	No Fee	DD B F
	Boys to Men	Boys to Men	V016	No Fee	98 9
	EPT_PKT_1	EPT PKT 1	V016	No Fee	33
	EPT_PKT_2	EPT PKT 2	1010	1.011	22 2
		Make CONFIDENTIAL Encounter	Balleton Exchange	20x 7905	1
94	CAMP S.	Part 3: Hepatitis	Sand Street Street	50.00	1 0
	99211STD	(STD) Office Visit	V77.99	26.00	IZ
	86708	Hepatitis A AB (titer)	V77.99	23.00	
	86706	Hepatitis B Surface AB	V77.99	No Fee	
	HC	Hepatitis C Project	V77.99	24.00	1
	86803	Hepatitis C (venipuncture)	COLUMN SECULO	WELDOWS !!	
GA.		Part 4: Hepatitis	V65.44	50.00	1
	99401	HIVT&C Risk Reduction Counseling Visit	V65.44	No Fee	
	99401RES	HIV T&C Post Visit		marks.	72 2.
	or the first the	Part 5: Miscellaneous Services	Taren en	No Fee	Office Use Only
	IMC	Immunization Check	V68.89	4.00	DSHS Coopers? Y N
	81025	Pregnancy Test	132.0	No Fee	Santa Analysis .
	87168	Head Check	000	No Fee	Bill
	HEPRESULT	Hepatitis Results	521.00	15.00	
	D1203	Topical Fluoride	-	27.58	
	D9999	Family Oral Health Ed	521.00	DEREN CHAN	1
-	93770	Blood Pressure Screening	796.2	No Fee	
	MMRR	MMR Results	000	No Fee	Encounter Enlared
	VARR	Varicella Results	000	No Fee	W
	2.00	Make CONFIDENTIAL Encounter			Aint Due
					Ricpt#:
					Control of Charles I Court Court 1
			Date:		Cash () Check () Credit Card () Amil Paid

S:/Administration/Policies, Procedures, Forms and Documents/Forms/Personal Health/101101 SKR CLINIC ENCOUNTER

Q. Fee Waiver for Financial Hardship Form



Fee Waiver for Financial Hardship

Under the Hardship write-off policy approved by the Benton Franklin Health District's

Board of Health on 2/27/97: Client Name Client Birth date Meets the criteria of need to have the fee waived for the following services: BFHD Services requested For the following reason: The services given have been determined to be necessary for the public health protection of the client, their family, and the community, therefore this fee adjustment has been Bonnie Hall, Billing Department Manager Date Approved

BFHD Clerk: Be sure to write "FEE Waiver Attached" to the top of the encounter form to insure that the charges are adjusted properly

Total Adjustment:

Account Number:



R. Immunization Consent – Grays Harbor

Grays Harbor County Public Health and Social Services Department 2109 Sumner Avenue Aberdeen, WA 98520

Immunization Consent Form

A Er	DOB/ Fecha de necliniento		Middle/Inicial de segundo i	First/Primer nombre	Last Name/Apellido
ilgo Post	Zip/Código	ate/Estado	City/Ciudad	omicilio	Address/Dirección de d
Cóc	Zip/	ate/Estado	City/Ciudad	omicilio	Address/Dirección de d

I have read the information sheets about the vaccines/biologics circled below. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccines/biologics and request that they be given to me or the person named above for whom I am authorized to make this request.

He leido las nojas informativas de las vacunas señaladas abajo. He tenido la oportunidad de hacer preguntas que me han respondido satisfactoriamente. Entiendo los beneficios y los riesgos de estas vacunas y pido que me las administrem a mi o a la persona que se menciona aquí, para la cual estoy autorizado a hacer esta soficitud.

X		
Signature of person to receive vaccine/biologic or authorized person	Date	
Firma de la persona que reciba las vacunas o persona autorizada	Fecha	

Please answer the questions below for person receiving immunizations Contests por favor preguntas abajo para persona inmunizaciones recipientes	Yes Si	No
is the patient sick today?		-
El paciente está enfermo hoy?		
Does the patient or anyone living with or caring for the patient have cancer, leukemia. AIDS, or any other immune system problem?		
¿El paciente o personas que viven o cuidan al paciente, tienen cáncer leucernia. SIDA, u otros problemas de immunidad?		
Does the patient or anyona living with or caring for them take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?		
¿El paciente o las personas que viven o cuidan al paciente toman cortisona, predirisona, otros esteriodes, drogas anticancerigenas, o tratamientos de rayos X?		
Is the patient prone to fainting or breath holding?		-
¿El paciente está predispuesto a desmayarse o a quedarse sin aliento?		
Does the patient have allergies to medications, eggs or any vaccines?		
¿El paciente tiene alergias a medicamentos, huevos o la algunas vacunas?		
Has the patient ever had a serious reaction to a vaccine in the past?		
¿El paciente ha tenido alguna vez una reacción grave a alguna vacuna en el pasado?		
Has the patient ever had saizures or a neurological problem?		
¿El paciente ha tenido alguna vez convulsiones o ataques o una enfermedad neurológica?	144	
Has the patient received a transfusion of blood, plasma or a medicine called immune globulin in the past 6 months?		
LEI paciente ha recibido una transfusión de sangre, piasma, o una medicina llamada globulina Inmune en los últimos 6 mases ?		
s the patient pregnant or at risk of becoming pregnant within the next 3 months?		
La paciente está embarazada o está en riosgo de quedar embarazada en los próximos 3 meses?		

C'Durr (julie Doiktop Jefferson County Water Resource) Appendice of Jimmunization Convent Grays (tarbor doc-

VACCINE (Circle)		FORM	MANUFACTURER & LOT#	DOSAGE	ROUTE/SITE OF INJECTION
DTaP-DT DTaP/HepB/IPV DTaP/Hib/IPV	DTaP-DT-DTaP/HepB/IPV DTap/Hib/IPV 1 2 3 4 5	05-17-07	Aventis/SKB	0.5oc	IM + LD. F.D. LVL RVI.
Tdap Td	Tdap Td	11-18-08	Aventis/SKB	0.5cc	M - LD RD
Polio	IPV 1.2.3.4.5	01-01-00	Aventis	0.5a:	SQ - LA RA LT RT IM - LD RD LVL RVL
RIB	HIB 1234	12-16-98	Aventis/Wyeth	0.500	IM - LD RD LVL RVL
MMR MMRV	MMR 12 MMRV 1	03-13-08 05-21-10	Merck	0.5cc	SQ - LA RA LT RT
HEP B Twinrix Hep A&B	Ped / Adult 1 2 3 Adult 1 2 3 4	07-18-07	Merck/SKB	0.5ce/1.0cc	IM + LD RD LVL RVL
Varicella	1 2	03-13-08	Merek	U Scc	SQ - LA RA LT RT
PCV	1234	04-16-10	Wyeth	0.5cc	IM - LO RO LVL RVL
HEP A	Ped / Adult 12	03 21 06	Merck/SKB	0.6cc/1.0cc	IM - LD RD LVL RVL
HPV	1 2 3	03-30-10	Merck	0.500	M-LD RD
Rotavirus	PO 1 2 3	05-14-10	Merck	2 0cc	РО
Pneumonia->2yrs	1 2	10:06:09	WysttvMerck	0 6cc	IM - ED RD LVL RVL
Meningococcal	1	01 28 08	Aventis	0 5 cc	IM - LO RO
Influenza	1 2	10-02-10	Sanoti/Medimmune/Novartis	0.25ce/0.5ec	M-LD RD LYL RVL
				0.2ml	Intranasal

immurization history and plan reviewed and discussed.

o Post immunization instructions given

x	
Signature of vaccine/biologic administrator	Date Administered

C Dampulie Doktop Jefferson County Water Resources Appendices R. Immunization, Convent Cinys Harbondo.

S. Immunization Consent – Spokane

S #			N	ame	(L	.a	st, F	-irs	st)							ľ	,	OE	٥.		
Spokan	e Region	al	Health I	Distr	ic	t	: 1	SR	HL	D) – 1	101	1	w	College,	Spol	ka	n	е	w	Ά	992	201
	3.00													ng Form			-			- 1		
														0						1	YES	NO
1. Are you sic	k or have a hig	gh fe	ver today?																			
	e severe aller	gies	to any med	ications	5, 1	lo	od	, or														
	If yes, what?_	_			-	_	_		F	or flu va	ccine	: 6	egg	s, gelatin or thi	imeros	al.					\Box	
Have you h	ad a serious re	eacti	ion to a vac	cine in	the	e p	pa	st?														Ш
4. Have you h	ad a history of	f seiz	zures, or Gu	illain B	arr	é	?															
Any immun	e system prob	lems	s?																			
6. Any daily st	teroid medicati	ions	or blood tra	nsfusio	ns	ir	n t	he p	ast :	3 months	?											
	Childbearing may become										accin	е	fra	m MDV, give th	nimeros	al	no	tic	(e)			
8. Have you re	eceived any va	accin	nations in the	e past	4 w	re	ek	(5?	lf y	es, what	vaco	in	es	?					_			
9. Any history	of asthma or s	smol	king? If yes,	recom	me	en	nd	pneu	ımo	nia vacci	ne.											
have received ad explained to r the person na state immuniza	me and und amed above fo	erst	and the info	ormati	on	p	ого	vide	d to	o me. I re	que	st	th	at the vaccine	s chec	ke	d t	be	low	be	give	n to n
DTaP/DT (Hepatitis A		П			Hep	atiti	s B		П		HPV		П]	nflu	en:	za (sh	ot)
			Meningoco		ti	Г	Ť		,01111		_	Н		1		T		-				PPV2
Influenza (I	nasai) į						_	MM	R			ш	ᆫ	PCV			_	Ш	Pne	um	O III a	
Polio (IPV)		Ī	Rabies		İ	Ī		MM		ıs				PCV Shingles				7			s (Td	
		H	1			Ī			aviru					1].	Teta	nu	s (Td	
Polio (IPV) TdaP			Rabies Typhoid*					Rota	aviru cella	а				Shingles].	Teta	nu	s (Td	1
Polio (IPV)		ent/L	Rabies Typhoid*	ian	in			Vari MM	cella IRV	Date	n P			Shingles Yellow Fever' Other (specify].	Teta	nu	s (Td	1
Polio (IPV) TdaP			Rabies Typhoid*	ian				Vari MM	aviru cella IRV	a	n R	e		Shingles Yellow Fever' Other (specify	0	3 5	12:],	Com	nu	s (Td	IS orta
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Polio (IPV) TdaP HIB Signature of P	0.5ml; IM 0.5ml; IM	V	Rabies Typhoid* egal Guard	ian Vacc		L	9	Vari MM	nini MPC	Date istration MRV ediarix DTAP/IPV entacel	/Нер	В	4	Shingles Yellow Fever Other (specify ord 0.5ml; SQ	VIS VIS	Cc 3/1	m 8/0	1/ bi 08	Teta Com	nbir	s (Td)	IS orto
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject)	0.5ml; IM 0.5ml; IM 0.5ml; IM	V	Rabies Typhoid* egal Guard (IS 5/17/07 IS 5/17/07 S 08/10/10	Vacc Site Site			•	Vari MM	nini MI	Date Istratio MRV ediarix DTaP/IPV entacel DTaP/IPV	/Hep	В)	4	Shingles Yellow Fever' Other (specify ord 0.5ml; SQ 0.5ml; IM 0.5ml; IM	VIS VIS	Cc 9/1 Cc 9/1	8/0 8/0	1/ bii 08	Teta Com	nbir	Site:	IS orta
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25 or 0.5ml; IM 1.0ml; IM	V	Rabies Typhoid* egal Guard 15 5/17/07 15 5/17/07 15 08/10/10 15 3/21/06	Vacco Site Site			2	Vari MM	nini MIRV	Date istration MRV ediarix ortap//PV entace OTap//PV CV (Prev Conjugat	/Hep /Hib nar) e)	В)	4	Shingles Yellow Fever's Other (specify) 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM	VIS VIS VIS	Cc 9/1 Cc 9/1 S 4	8/0 8/0 8/0	1/ bii 08 6/	Teta Com	nbir	Site: Site: Site:	IS orta
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Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped)	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25 or 0.5ml; IM 1.0ml; IM 1.0ml; IM	V	Rabies Typhoid* egal Guard IS 5/17/07 IS 5/17/07 IS 08/10/10 IS 3/21/06 IS 7/18/07	Vacco Site Site Site Site			e /	Vari MM	nini MIPO (D) PO (C) PO (P)	Date istration MRV ediarix DataPilpV entacel DapilpV CV (Prev conjugat neumoni Polysacci ables	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) ord 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM	VIS VIS VIS VIS	Cc 9/1 Cc 9/1 S 4	8/0 8/0 8/0 8/0	1/ 1bi 08 6/ 06/	Teta Com 10 ned 10 709	nbir	Site. Site. Site. Site. Site. Site.	IS orfar
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HEP B-Adult HEP B (Ped)	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25ml; IM 1.0ml; IM 0.5ml; IM 1.0ml; IM 1.0ml; IM	V	Rabies Typhoid* egal Guard (IS 5/17/07 IS 5/17/07 IS 08/10/10 IS 3/21/06 IIS 3/21/06 IIS 7/18/07	Vacci Site Site Site Site Site Site			a	Vari MM	nini MI Pe (D Pe (C Pr (P	Date istration MRV ediarix DTaP/IPV entacel DTaP/IPV CV (Prev conjugat neumoni Polysacci ables otavirus	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) ord 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 2.0ml; Oral	VIS VIS VIS VIS VIS	Cc 9/1 Cc 9/1 S 4	8/0 8/0 8/0 /10 0/0	1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1	10 ned 10 709	nbir	Site Site Site Site Site Site	IS ortal
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HEP B-Adult HEP B (Ped) HIB	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25 or 0.25 or 0.5ml; IM 1.0ml; IM 0.5ml; IM 0.5ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* regal Guard ris 5/17/07 ris 5/17/07 ris 3/21/06 ris 3/21/06 ris 7/18/07 ris 7/18/07 ris 7/18/07	Vacco Site Site Site Site Site Site Site Site				Vari MM	nini MIPO PO (D) PO (C) PO PO (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po (C) Po	Date istration MRV ediarix DTaP/IPV entacel DTaP/IPV CV (Prev conjugat neumoni olysacci abies otavirus d	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) ord 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 2.0ml; IM 2.0ml; IM	VIS VIS VIS VIS VIS VIS VIS	Cc 9/1 Cc 9/1 S 4 S 10 S 5	8/0 8/0 8/0 /16 0/0	1/ bii 08 6/ 06/ 4/ 18/	10 ned ned 10 709 709	nbir	Site Site Site Site Site Site	IS orta
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HEP B-Adult HEP B (Ped)	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25ml; IM 1.0ml; IM 0.5ml; IM 1.0ml; IM 1.0ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* egal Guard (IS 5/17/07 IS 5/17/07 IS 08/10/10 IS 3/21/06 IIS 3/21/06 IIS 7/18/07	Vacci Site Site Site Site Site Site		le l	a	Vari MM	nini MIPO (D) Pr (C) Pr (P) Rc	Date istration MRV ediarix DTaP/IPV entacel DTaP/IPV CV (Prev conjugat neumoni Polysacci ables otavirus	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) ord 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 2.0ml; Oral	VIS VIS VIS VIS VIS	Cc 9/1 Cc 9/1 S 4 S 10 S 10	8/0 8/0 8/0 /16 0/0	1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1	10 ned ned 10 709 709	nbir	Site Site Site Site Site Site	IS (refar
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HEP B-Adult HEP B (Ped) HIB HPV IPV	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5m; IM 0.5m; IM 0.5m; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* egal Guard ils 5/17/07 ils 5/17/07 ils 08/10/10 ils 3/21/06 ils 3/21/06 ils 7/18/07 ils 7/18/07 ils 7/18/07 ils 7/18/07 ils 12/16/98 ils 3/30/10	Vacco Site Site Site Site Site Site Site Site		ine ine	•	Vari MM	nini MIRV Pe (D PC (P Rc Tc	Date istratio istratio imrv ediarix ediarix ediarix ornap/ipv ornap/ipv conjugat nolysacc abies otavirus d dap winrix	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) O.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 2.0ml; Oral 0.5ml; IM 0.5ml; IM	VIS	Cc 9/1 Cc 9/1 S 4 S 10 S 10 V /06	0/0 0/16 0/16 0/16 0/16 0/16 0/16 0/16	1/ 108 6/ 18/ 18/ 18/	Teta Com 10 ned 10 10 709 10 708 708	nbir	Site Site Site Site Site Site Site Site	IS orta
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HEP B-Adult HEP B (Ped) HIB HPV	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* egal Guard ils 5/17/07 ils 5/17/07 ils 08/10/10 ils 3/21/06 ils 3/21/06 ils 7/18/07 ils 7/18/07 ils 7/18/07 ils 7/18/07 ils 12/16/98 ils 3/30/10	Vacco Site Site Site Site Site Site Site Site				Vari MM	nini MIPO (D) PO (C) PO (C) PO (C) TO	Date istration MRV ediarix DTaP/IPV entacel DTaP/IPV Conjugat nolysacci abies otavirus d dap	/Hep /Hib nar) e) a)))	Shingles Yellow Fever' Other (specify) Office (specify) O.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 1.0ml; IM 1.0ml; IM 0.5ml; IM 0.5ml; IM	VIS	Cc 9/1 Cc 9/1 S 4 S 10 S 10 S 10 V	0/0 0/0 0/1 0/0 0/1 0/1 0/1 0/1 0/1 0/1	11/1 bio bio 6/6/6/6/6/18 18/18/18/18/18/18/18/18/18/18/18/18/18/1	Teta Com 10 ned 10 709 10 708 708	nbir	Site Site Site Site Site Site Site Site	IS ortan
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HIB HPV IPV ISG	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.25 or 0.5ml; IM 1.0ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* egal Guard IIS 5/17/07 IIS 5/17/07 IS 08/10/10 IIS 3/21/06 IIS 3/21/06 IIS 7/18/07 IIS 7/18/07 IIS 12/16/98 IIS 3/30/10 IIS 1/1/00	Vacco Site Site Site Site Site Site Site Site			•	Vari MM	nini MI Pe (D Pe (C Pr (P To	Date istratio imax imax imax istratio imax imax imax imax imax imax imax imax	/Hep /Hib nar) e) a hario)))	Shingles Yellow Fever' Other (specify) 0.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 0.5ml; IM	VIS	000 00/1 00/1 00/1 00/1 00/1 00/1 00/1	8/0 /16 0/0 /14 1/1 1/1 1/1 1/1 1/1 1/1 1/1	11/1 bio8 6/06 18/18/9/	Teta Com 10 ned 10 709 708 708 708 708	nbir	Site Site Site Site Site Site Site Site	IS ortan
Polio (IPV) TdaP HIB Signature of P DTaP DT Flu (Inject) HEP A-Adult HEP A (Ped) HIB HPV IPV ISG Meningococcal	0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM 0.5ml; IM	V V V V V V V V V V V V V V V V V V V	Rabies Typhoid* egal Guard IIS 5/17/07 IIS 5/17/07 IS 08/10/10 IIS 3/21/06 IIS 3/21/06 IIS 7/18/07 IIS 1/18/07 IIS 1/18/07 IIS 1/18/08	Vacci Site Site Site Site Site Site Site Sit				Vari MM	mini Mi Pro (CC Pro (CC Tro	Date istratio istratio imrv ediarix DTaP/IPV ontacel TaP/IPV Conjugat neumoni oolysacc abies otavirus d dap winrix yphoid	/Hep /Hib nar) e) a hario)))	Shingles Yellow Fever' Other (specify) Office (specify) O.5ml; SQ 0.5ml; IM 0.5ml; IM 0.5ml; IM 1.0ml; IM 1.0ml; IM 0.5ml; IM	VIS	Cc 9/1 Cc 9/1 S 4 G 10 G 10 S 5 G 17 V V/06 S 5	8/0 /16 0/0 /1/1 1/1 1/1 1/1 1/1 1/1	11/1/bibibibibibibibibibibibibibibibibib	Teta Com 10 ned 10 709 10 708 708 708 04 008	nbir	Site Site Site Site Site Site Site Site	IS ortan

10/12/10 *For travel vaccinations – complete reverse side of form.

For Travel Vaccinations Only:

Travel Information:	Departure Date:			Return Date:	
Destination (City, Country)	Where will yo	u stay?	Rural?	Length of Stay	
Information on Malaria Prophy	laxis Given:	Yes	□ No	□ N/A	

Information for Health Professionals about the Screening Questionnaire for Immunization

- 1. Are you sick today? There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1,2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otilis meda, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

 2. Do you have allergies to medications, food, or any vaccine? History of enaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) from a previous dose of vaccine or vaccine component is a contraindication for further doses. For example, if a person experiences anaphylasis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. Local reactions (e.g., a red eye following instillation of ophthalmic solution) are not contraindications. For an extensive stable of vaccine components, see reference 3.

 3. Have you had a serious reaction to a vaccine in the past? History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine components is a contraindication for subsequent doses (1), History of encephalopathy within 7 days following DTP/DT3P is a contraindication for further doses of pertussis-containing vaccine. Precautions to DT3P (not Td3p) include the following: (a) setzure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 hours within 48 hours of a dose, (d) (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other averse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines and efferted when a precaution is present. However, situations may arise when the benefit cutweighs the risk (e.g., communi
- outbreax).

 4. Have you had a seizure, brain, or nerve problem? DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of Tdap. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizure, vaccinate as usual but consider the use of actentinophen or inburpofen to minimize fever. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) "Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Inactivated influenza vaccine (TTV), if GBS has occurred within 6 weeks of prior TTV, vaccinate with TTV if at high risk for severe influenza complications; 3) LAIV: if GBS history, do not give LAIV; 4) MCV4: avoid vaccinating persons unless in recommended risk groups.

 5. Do you have cancer, leukemia, AIDS, or any other immune system problem? Live virus vaccines (e.g., MMR, varicella, and the intransatel live attenuated influenza vaccine (LAIV) are usually contraindicated in immunocompromised. However, there are exceptions. For example, MMR and varicella vaccines are recommended for asymptomatic HIV refered children who do not have evidence of severe immunosuppression. For details, consult the ACIP recommendations (4, 5, 6).
- 6. Have you taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? Live virus vaccines (e.g., MMR, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can only be given to healthy non-pregnant individuals ages 5–49
- varis, and the metrow transplant patients, see reference 7. Lav can only be given to hearthy non-pregnant individuals ages 3–49 years.

 7. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? Certain live virus vaccines (e.g., MMR, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the 2003 Red Book, p. 423, for the most current information on intervals between immune globulin or blood product administration and MMR or varicella vaccination (1, 2).

 8. Are you pregnant or is there a chance you could become pregnant during the next month? Live virus vaccines (e.g., MMR, varicella, LAIV) are contraindicated prior to and during pregnancy because of the theoretical risk of virus transmission to the fetus (1,6). Sexually active young women who receive MMR or varicella vaccination should be instructed to practice careful contraception for one month following receipt of either vaccine (8, 9). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy, however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Patients may be given Td routinely during 2nd or 3rd trimester if due for booster; if up-to-date and no history of Tdap, give 1 dose in immediate protection is needed. immediate post-partum period.
- 3. Have you received any vaccinations in the past 4 weeks? If the child was given either live attenuated influenza vaccine (FluMist®) or an injectable live virus vaccine (e.g., MMR. varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

10/12/10 *For travel vaccinations - complete reverse side of form

T. Immunization Consent – Jefferson

Pre arrangements have been made to bill - Agency;

Jefferson County Public Health - Immunization Consent Patient Name Mailing Address State Zip Code Printed Name of Parent or Guardian (Parent or Guardian must authorize immunization on reverse side for a patient under age 18) Unsure Yes No Has the patient: Experienced fever, vomiting or diarrhea today? П П П Received any other immunizations during the past month? Had allergies to medications, eggs, yeast, gelatin, other foods or chemicals? Had a serious reaction or allergy to a vaccine in the past? Had the chickenpox? Approximate date or age of disease: Does the patient or a family member have seizures, changing neurological disorder, or Guillain-Barre syndrome? Ever had thrombocytopenia (decreased platelets/increase bleeding)? Received blood, plasma, or immune globulin in the past six months? Have a bleeding disorder or take medications that increased bleeding? П Are you Pregnant or planning to be pregnant within the next month? Had history of thymus disease, thymectomy, or intussusception? Does the patient or anyone in the home have: cancer, an immune disorder, a spleen removed, an organ transplant, or being treated with medications for rheumatoid, psoriasis, or autoimmune disease, or medications that suppress the immune system? Is the patient or anyone at home HIV positive? VFC Status * Required for State-Supplied Vaccine Select ONE Payment Method Below: Medicaid Alaskan Native ♦ Bill My Insurance or Medicaid Medicaid? ☐ Yes ☐ No Private Insurance? ☐ Yes ☐ No Is there a Co-Pay? Yes No Amount of Co-Pay \$ Insurance Company Name: I authorize my insurance benefits be paid directly to the provider. I am financially responsible for making any co-payments at the time of service and am financially responsible for any balance due. I also authorize the provider or insurance company to release any information required for this claim. Request a Fee Adjustment Based on Income Childhood immunization fees are based on a sliding scale dependent upon income. If you do not have insurance or medical coupons and feel you may qualify for a discount, please provide us with the following information: Gross Monthly Pay: 8_ Number of people in household supported by this income Date I certify that the financial information provided is accurate and current. ♦ Pay Full Fee at Time of Service Signature

JK/vacadmrec.6-10



U. Travel Appointment Form – Benton Franklin

nera/LifeWise Group Health Blue Cross Aetna Travel Immunization Worksheet	Appt. Date:	
ravel Immunization Worksheet	Appt Time:	
Day Fhone #: Acct. #:		
Travel Departure Date:	() Health Hints	HANDOU
Length of Stay:	() Hepatitis A	() Hepatitis B
	() Schisto	() Diarrhea
Subscriber	C Chagas	High Attitude () Pocket Doctor
Allerges	() Children & T () Jap. Enc.	
	() Other	
HIGH Pisk	MALARIARISK Yes No	TRAVELER'S
Trekking Backpacking Homes of Netionals	RX:	Discribes RX
II.	-	
	-	
dose		
\$ 47		
\$ 37		
350		
500		
\$503		
\$32		
\$32		
\$50		
\$46		
\$23		
\$160		
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5.60		
Sea		
	Subsernic HIGH Risk: Treklaring Badryase Pre-Auth	Subsember HIGH Risk Tresdang Beskpacking Homes of Nationals Pre-dusk in Estimate NOTES NOTES



V1. Sliding Fee Schedule – Grays Harbor

Grays Harbor County Public Health and Social Services Dept Income Conversion Table. Client Income to Fee/Discount Category Fee Based on Gross Income and Family Size. Effective August 3, 2010.

FPL 0%	%0		102 F													
ly Size	09% to 1009	9	101% to 125%	25%	29% 126% to 150%	150%	43% 151% to 175%	175%	3/% 176% to 200%	,200%	201% to 2	225%	226% to 250%	250%	251%	100% 251% and up
		-											-		ŀ	
100	0 10,	0,830	10,831	13,538	13,539	16,245	16,246	18,953	18,954	21,660	21,661	24,368	24,369	27,075	27,076	666,666
64	0 14,	67D	14,571	18,213	18,214	21,855	21,858	25,498	25,499	29,140	29,141	32 783	32,784	36,425	36,426	886,888
63	0 18,	310	18,311	22,888	22,889	27,465	27,466	32,043	32,044	36,620	36,621	41 198	41,199	45,775	45,776	999,999
4	0 22	22,050	22,051	27.563	27.564	33,075	33,076	38,588	38,589	44,100	44,101	49,613	49,614	55,125	56,126	666'666
5	0 25,	790	25,791	32,238	32,239	38,685	38,686	45,133	45,134	51,580	51,581	58 028	58,029	64,475	64,476	666,666
0	0 23	530	29,531	36,913	36,914	44 295	44,296	51,678	51,679	29,060	59,061	66,443	66,444	73,825	73,826	666 666
7	0 33,	270	33,271	41,588	41,589	49,905	49,906	58,223	58,224	66,540	66,541	74.858	74,859	83,175	83,176	666,966
10	0 37,	010	37,011	46,263	46,264	55,515	55,516	64,768	64,769	74,020	74,021	83 273	83,274	92,525	92,526	999,999
														11		
Forfa	mily units	s more	For family units more than 8 members add \$3740 for each additional member	embers a	dd \$3740	for each	additional	member								Ī

FPL	340		149%	39	29%	9	439	9	57%	.0	719	9	86%	9	100	9%
	0% to 10	%00	ot %101	125%	126% to	150%	151% to	175%	176% to 200%	200%	201% to 2	225%	226% to 250%	250%	251% and up	dn pu
Family Size	ds			-						9						
	0	903	904	1,129	1,130	1,355	1,356	1,580	1,581	1,806	1,807	2 032	2,033	2,258		999,999
54	0	1,214	1,215	1,518	1,519	1,821	1,822	2,125	2,126	2,428	2 429	2 732	2,733	3,035	3,036	999,999
63	0	1,526	1,527	1,908	1,909	2,289	2,290	2,671	2,672	3,052	3,053	3 434	3,435	3,815	3,816	666,666
7	0	1,838	1,839	2,298	2,299	2,757	2,758	3,217	3,218	3,676	3,877	4138	4,137	4,595	4,596	666 666
40	0	2,149	2,150	2,686	2,687	3,224	3,225	3,761	3,762	4,298	4,299	4.835	4,836	5,373	5,374	666,666
9	0	2,461	2,462	3,076	3,077	3,692	3,693	4,307	4,308	4,922	4,923	5 537	5,538	6,153	6,154	888,888
7	0	2,773	2,774	3,466	3,467	4,160	4,161	4,853	4,854	5,546	5,547	6.239	6,240	6,933	6,934	999,999
00	0	3,084	3,085	3,865	3,856	4,626	4,627	5,397	5,398	6,168	6,169	6,939	6,940	7,710	7,711	666 666
		ľ														
ш	For family units more than 8 members add \$311 for each additional member	inits mor	re than 8 m	s sadmer	dd \$311 t	or each a	dditional n	nember.		4		Ŧ,		Ī		1

G \Everyone\Forms\General\2010 Sliding Fee Schedule 08-03-10

V2. Sliding Fee Scale - Jefferson

JEFFERSON COUNTY PUBLIC HEATH CLINICAL SERVICES INCLUDING FAMILY PLANNING INCOME CONVERSION TABLE: CLIENT INCOME TO FEE/DISCOUNT CATEGORY EFFECTIVE MARCH, 2 2009

FPL	<100%	101 - 125%	126 - 150%	151 - 175%	26 - 150% 151 - 175% 176 - 200% 201 - 225%	201 - 225%	226 - 250%	>25,
Sliding Fee	0%pay	14%pay	29%pay	43%pay	57%pay	71%pay	86%pay	400%
Family Size								
,	10,830	10,831 - 13,538	13,539 - 16,245	5 15,246 - 18,953	18,954 - 21,660	21,661 - 24,368	24,369 - 27,075	27
7	14,570	14,571 - 18,213	18,214 - 21,855	5 21,858 - 25,498	25,499 - 29,140	29,141 32,783	32,784 - 36,425	36
cr3	18,310	18,311 - 22,888	22,889 - 27,465	5 27,466 - 32,043	32,044 - 36,620	36,621 - 41,198	41,199 - 45,775	45
- 4	22,050	22,051 - 27,563	27,584 - 33,075	5 33,076 - 38,588	38,589 - 44,100	44,101 - 49,813	49,614 - 55,125	95.
ŵ	25,790	25,791 - 32,238	32,239 - 38,685	5 38,686 - 45,133	45,134 - 51,580	51,581 - 58,028	58,029 - 64,475	64
9	29,530	29,531 - 36,913	36,914 - 44,295	5 44,296 - 51,678	51,679 - 59,060	59,061 - 66,443	66,444 - 73,825	73
7	33,270	33,271 - 41,588	41,589 - 49,905	5 49,906 - 58,223	58,224 - 66,540	66,541 - 74,858	74,859 - 83,175	83
80	37,010	37,011 - 46,263	46,264 - 55,515	5 55,516 - 64,768	64,769 - 74,020	74,021 - 83,273	83,274 - 92,525	92,
For family unit	s with more th	For family units with more than 8 members add \$3740 for each additional member	\$3740 for each a	dditional member				

FPL	~100%	101 - 125%	126 - 150%	20%	151 - 175%	2%	176 - 200%	%	201 - 225%	%5%	226 - 250%	%0	>251%
Sliding Fee	0%pay	14%pay	29%pay	bay	43%pay	Λ	57%pay	17	71%pay	ΛŁ	86%pay	^	100%pay
Family Size													
-	903	904 - 1,129	1,130 -	1,355	1,356 -	1,580	1,581 - 1	908	1,807	2,032	2,033 -	2,258	2,259
7	1,214	1,215 - 1,518	1,519 -	1,821	1,822 -	2,125	2,126 - 2	2,428	2,429 -	2,732	2,733 -	3,035	3,036
m	1,526	1,527 - 1,908	1,909	2,289	2,290 -	2,671	2.672 - 3	3,052	3,053 -	3,434	3,435 -	3,815	3,816
4	1,838	1,839 - 2,298	2,299 -	2,757	2,758	3,217	3,218 - 3	3.676	3,677 -	4,136	4,137	4,595	4,596
Ω.	2,149	2,150 - 2,686	2.687.	3,224	3,225 -	3,761	3.762 - 4	4,298	4,299 -	4,835	4.836 -	5,373	5,374
9	2,461	2,462 - 3,076	3,077 -	3,692	3,693 -	4,307	4,308 - 4	4,922	4,923 -	5,537	5,538 -	6,153	6,154
7	2,773	2,774 - 3,466	3,467 -	4.160	4,161	4.853	4,854 - 5	5,546	5,547 -	6,239	6,240 -	6,933	6,934
œ	3.084	3,085 - 3,855	3,856 -	4.626	4.627 -	5.397	5.398 - 6	6,168	6.169 -	6.939	6.940 -	7.710	7.71

Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201

Flename; p/finfillee schedula/V2_SlidingfreeScale-Jefferson UPDATE quis other #samples DJD: 9/20/2011

V3. Fee Schedule - Jefferson

EFFECTIVE NOVEMBER 03, 20	010		
VACCINE	CLIENT COST		-
HPV	\$139.00		4 - 1
ADULT FLU	\$25.00		
HEPATITIS A	\$46,00		
HEPATITIS B	\$60.00		
HEPATITIS A/B COMBO	\$91.00		1 -1
IMMUNE GLÖBULIN	\$48,00		
MENACTRA	\$209.00		
MENINGOCOCCAL	\$209.00		
MMR	\$58,00		
PNEUMOCOCCAL	\$100.00		
POLIO	\$50.00		
TETANUS/DIPTHERIA-Td	\$30,00		+ +
TETANUS/DIPTHERIA, ADACEL-Tdap	\$43.00		
ORAL TYPHOID	\$42,00		
INJECTABLE TYPHOID	\$61,00		
VARICELLA	\$103.00		
YELLOW FEVER - SINGLE DS	\$92,00		1 - 1
JAPENESE ENCEPHALITIS	\$107.00		
JAPENESE ENCEPHALITIS - IXIARO	\$219.00		
RABIES	\$203.00		
TB TEST (ELIGIBLE FOR SLIDING FEE SCALE)	\$7.00		
COSTS ARE PER DOSE - COST OF VACCINES NOT ELIG	BLE FOR SLID	NG FEE SCA	LE
VACCINE ADMINISTRATION FEE - IST VACCINE VACCINE ADMINISTRATION FEE - EACH ADDITIONAL VACCINE	\$15,00 \$10.00	CASH D/C	\$15.00 \$10.00
\$28.00 OFFICE VISIT (1-10 MINUTES) PLUS VACCINE ADMINIST TO COST OF VACCINE FOR WALK IN CLINCS - OFFICE VISIT FEE SLIDING FEE SCALE	and the second second second second	Order Section 1	

ADDITION TO COST OF VACCINE FOR WALK IN CLINCS - OFFICE VISIT FEE AND ADMINISTRATION FEE ELIGIBLE FOR SLIDING FEE SCALE
\$60.00 OFFICE VISIT (\$35.00 FOR EACH ADDITIONAL FAMILY MEMBERS SEEN AT THE SAME

APPOINTMENT) CHARGED IN ADDITION TO COST OF VACCINE AND ADMINISTRATION FEE FOR A TRAVELER'S CONSULTATION - TRAVEL VACCINES ARE GIVEN BY APPOINTMENT ONLY TRAVEL OFFICE VISIT AND ADMINISTRATION FEE ARE NOT ELIGIBLE FOR SLIDING FEE SCALE

FOR CLIENTS PAYING AT TIME OF SERVICE (NO INSURANCE BILLING) VACCINE ADMINISTRATION FEES WILL BE DISCOUNTED FOR PRIVATE SUPPLY VACCINE

COST FOR STATE SUPPLIED VACCINES FOR CHILDREN THROUGH AGE 18 = OFFICE VISIT PLUS VACCINE ADMINISTRATION FEE

VACCINE FEES ARE BASED ON CURRENT MEDICAID RATES OR ACQUISITION COST PLUS HANDLING, SHIPPING AND NURSING TIME AND ARE SUBJECT TO CHANGE WITHOUT NOTICE

V4a. Vaccine Administration Cost Calculator

Vaccine Calculator

This spreadsheet can be used to calculate the cost of each vaccine administration in a private practice.

Enter your responses into Column C. You can choose any time period you want but 12 months is recommended.

Rows in gray will automatically calculate. You do not need to fill these in.

COSTS RELATED TO ALL COLLECTIONS

Physician's tax, if any (state or local municipality) % Percent of revenues used by the billing/collections staff, department, or service Percentage of all claims denied/never paid

NUMBER OF VACCINES GIVEN

Total number of all vaccines administered during the period (CPT 90460) Number of additional antigens administered during the period (CPT 90461)

COST OF ADMINISTRATION For appointments for vaccines only (i.e. no doctor visit): number of hours spent by staff scheduling appointments, preparing charts, and checking in and out during the period Hourly wage of staff making appointments, etc. PERSONNEL COSTS FOR SCHEDULING, ETC.* #DIV/OI Hours spent over the period entering vaccines into registry Hourly salary of staff entering vaccines into registry PERSONNEL COSTS FOR ENTERING DATA INTO REGISTRY* #DIV/0! Number of hours staff spend on triage calls related to vaccines during the period Hourly wage of staff answering vaccine related triage calls PERSONNEL COSTS FOR VACCINE TRIAGE CALLS* #DIV/0! Staff time (in minutes) administering vaccine (include distribution of VIS, answering questions, drawing up vaccine, administering the injection, and documenting it). Assume this is a single antigen vaccine. Additional staff time, per antigen, for multiple-antigen vaccines. Hourly salary of staff administering vaccine PERSONNEL COSTS FOR ADMINISTERING VACCINE - INITIAL ANTIGEN® PERSONNEL COSTS FOR ADMINISTERING VACCINE - ADDITIONAL ANTIGEN* Average minutes per vaccine spent by physician answering vaccine questions, etc. Assume this is a single antigen vaccine. Average minutes per additional antigen for multiple-antigen vaccines Hourly salary of physician TOTAL PHYSICIAN WORK - INITIAL ANTIGEN"

Vaccine Calculator

TOTAL PHYSICIAN WORK - ADDITIONAL ANTIGEN*	\$	
Medical Supplies (1 pair non-sterile gloves, 7 feet of exam table paper, 1 OSHA-compliant syringe with needle, 1 CDC information sheet, 2 alcohol swabs, 1 band-aid) Cost of sharps containers used in the period		
Cost of sharps containers used in the period Percentage of sharps used in office that are vaccine-related Cost of disposal service for the period		959
TOTAL SUPPLIES AND SHARPS DISPOSAL	#0	OIV/O!
Total rent and utilities during the period		
Estimated percentage of rent and utilities attributable to vaccine-related appointments		
TOTAL RENT AND UTILITIES	#0)IV/0!
Total computer/EMR costs during the period Percent of computer/EMR costs attributable to vaccines		
TOTAL COMPUTER/EMR COSTS	#0	OIV/O!
TOTAL PROFESSIONAL LIABILITY INSURANCE**	\$	0.3
PHYSICIAN TAX COST - INITIAL ANTIGEN***	\$	
PHYSICIAN TAX COST - ADDITIONAL ANTIGEN***	\$	
BILLING/COLLECTIONS COST - INITIAL ANTIGEN***	\$	-
BILLING/COLLECTIONS COST - ADDITIONAL ANTIGEN***	\$	
TOTAL ADMINISTRATION EXPENSES - INITIAL ANTIGEN	#D	IV/0!
TOTAL ADMINISTRATION EXPENSES - ADDITIONAL ANTIGEN	#D	IV/0!

*NOTE: Once you enter wage information, benefits are automatically calculated at the rate of 40% of salary (supervised employees) and 30% (physicians).

**NOTE: Professional liability insurance is calculated using the Medicare non-geographically adjusted standard of 0.01 professional liability insurance (PLI) relative value units (RVUs). The PLI RVUs were then multiplied by the 2010 Medicare conversion factor (\$36.8729) to obtain the estimated professional liability insurance cost of \$0.37 per vaccine administered

***NOTE: Physician tax and billing cost are calculated based on a percentage of revenue. We assume revenue for the vaccine in question is 20% above purchase price and revenue for vaccine administration is equal to the 2010 Medicare rates for 90465 and 90466.

V4b. Vaccine Cost and Payment Comparison Spreadsheet

Vaccine Cost and Payment Comparison Spreadsheet

overhead and the second covering vaccine administration

Vaccine and Vaccine Overhead Section:

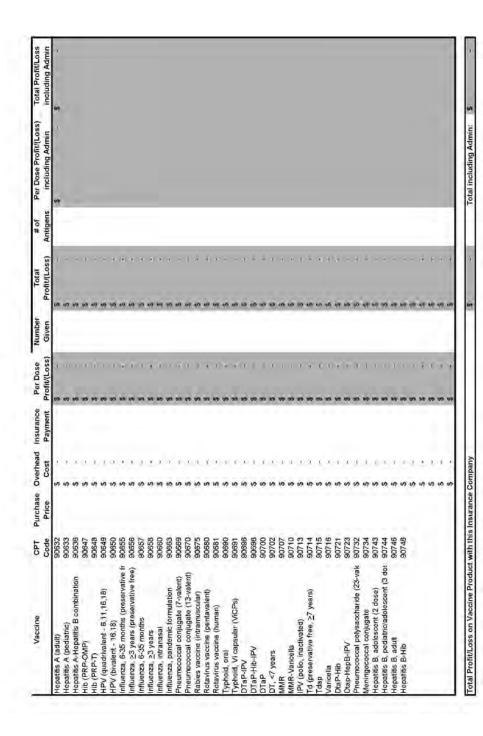
The vaccines are listed in Golumn B, with the CPT code for the vaccine listed in Column C. For the sake of completeness, some vaccines that are not very common or that are pending approval are included. Some of the known brand names are listed in the notes attached to Column B (per 2009 CPT book). To see a note, hover your cursor over a box that has a red triangle in the corner. The note will appear as a pop-up.

use, just right click on the appropriate line number and choose "delete". This will clean up the spreadsheet and If you are comfortable using Excel and want to get rid of lines with vaccines you know you will never make it easier to read.

ii. If you want to use a constant percentage over purchase price as your overhead (such as choosing a percentage between 17% and 20% as discussed in the AAP's Business Case for Pricing Vaccines, or using the regian value of 16% determined by a survey in Azizona), enter a percentage in Line 36, Column C. The prosastenet with then calculate the overtread based on the purchase price that you will enter in Column D.

you want to use the overhead you calculated using the Vaccine Cost Calculator for each vaccine, Leave 36, Column C blank and simply enter the overhead values from the calculator in Column E.

nee company in question pays for each vaccine. As you do so, the amount of profit per dose of vaccine carbidated for Column of lifetier is a loss, it will appear in parentheses.) If you then want to calculate the rolling so on the vaccine over a given period of fitne, enter the number of doses of that vaccine listered to patients with this insurance in Column H. The total profit (or loss) will calculate in Column I. the two methods above to fill in overhead cost, then fill in the values in Column F with the amount that the



Vaccine Administration Section

hen show you the total profit (or loss) on vaccines plus vaccine administration for that insurance company over Column D. If you have used the Vaccine Cost Calculator to calculate your cost of vaccine administration, enter ype of administration is performed over the desired period of time for patients with the insurance in question Column H) to calculate the total profit (or loss) on vaccine administration for the insurance. The last line will Expenses - Subsequent Vaccine" for the other codes). If you do not want to use the calculator, then you may calculate the profit (or loss) on each vaccine administration (Column G); then fill in the number of times each This section works in a similar fashion to the first section. The vaccine administration descriptors and CP he values in Column E (use the value from the calculator listed as "Total Administration Expenses - Initial codes are listed in Columns B and C. For reference, the 2009 Medicare values for the codes are listed in want to use the 2009 Medicare values instead. Then you can fill in the insurance payment (Column F) to /accine" for CPT codes 90465, 90467, 90471, and 90473; use the value listed as "Total Administration hat period of time.

Administration Type	CPT	2009	Cost Per	Insurance	Per Admin	Number	Total
	Code	Medicare	Admin	Payment	Profit/(Loss)	Performed	Profit/(Loss)
Initial antigen	90460	\$ 20.92					9
Susequent antigen	90461	\$ 10.46			69		69

Total Profit/Loss on Vaccine Administration with this Insurance Company

V4c. Vaccine Inventory Value

Vaccine Inventory Value Calculator

This spreadsheet can be used to calculate the actual dollar value of your inventory of vaccines at any given time, based on purchase price.

The vaccines are listed in Column B, with the CPT code for the vaccine listed in Column C. Some of the known brand names are listed in the notes attached to Column B (per 2010 CPT book). To see a note, hover your cursor over a box that has a red triangle in the corner. The note will appear as a pop-up.

If you stock any vaccines that are not included in the list, you can add them in the spaces in lines 63 through 70 at the bottom. If you are comfortable using Excel and want to get rid of lines with vaccines you know you will never use, just right click on the appropriate line number and choose "delete". This will clean up the spreadsheet and make it easier to read.

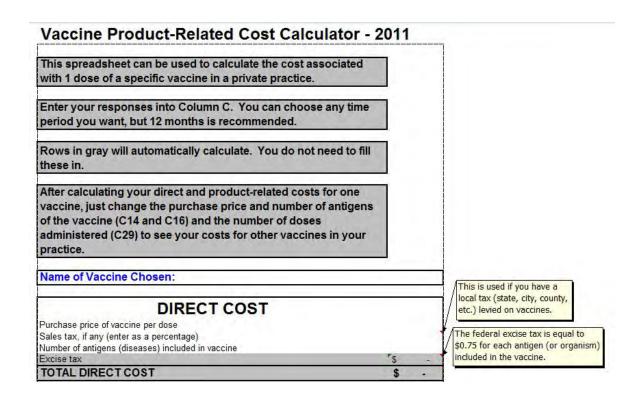
To use the spreadsheet, enter your purchase price, including excise tax and sales tax (if any), in Column D and enter the current number of doses of the vaccine that you have on hand (in your refrigerator) in Column E. Your total inventory value for each vaccine will show up in Column F and the total for all vaccines will be at the bottom (line 72).

You can also use this spreadsheet to calculate such things as the value of all vaccines given by your practice over a given period of time by entering the number of doses of each vaccine given instead of entering your current inventory.

Vaccine	CPT Code	Purchase Price	Current Inventory	Inventory Value
Hepatitis A (adult)	90632			\$ -
Hepatitis A (pediatric 2-dose schedule)	90633			\$ -
Hepatitis A-Hepatitis B combination	90636			5 -
Meningococcal-Hib	90644			\$ -
HIb (HbOC)	90645			\$ -
Hib (PRP-OMP)	90647			s -
Hib (PRP-T)	90648		4	5 -
HPV (quadrivalent - 6,11,16,18)	90649			\$ -
HPV (bivalent - 16,18)	90650		3	S -
Influenza, 6-35 months (preservative free)	90655			\$ -
Influenza ≥3 years (preservative free)	90656			\$ -
Influenza, 6-35 months	90657			\$
Influenza, ≥3 years	90658			5 -
Influenza, intranasal	90660			\$ -
Pneumococcal conjugate (13-valent)	90670			S -
Rotavirus vaccine (pentavalent)	90680			S -
Rotavirus vaccine (human)	90681			9 -

Total Inventory Value		\$	- 12
		5	
		5 5 5	0
		8	
		8	
		5 5 5	- 3
			1
		5	
Hepatitis B-Hib	90748	\$ \$	1
Hepatitis B, adult	90746	35	ī
Hepatitis B, pediatric/adolescent (3 dose)	90744	5	-
Hepatitis B, adolescent (2 dose)	90743	\$ 5	
Meningococcal conjugate	90734	8	1
Pneumococcal polysaccharide (23-valent)	90732	S	- 1
DtaP-HepB-IPV	90723	55	
DtaP-Hib	90721	5	
Varicella	90716	S	8
Tdap	90715	***	- 4
Td (preservative free, ≥7 years)	90714	\$	
IPV (polio, inactivated)	90713	\$	
MMR-Varicella	90710	* * * * * * * * * *	-
MMR	90707	5.	1
DT, <7 years	90702	5.	
DTaP	90700	3	-
DTaP-Hib-IPV	90698	\$	-
DTaP-IPV	90696	S	-

V4d. Vaccine Product-Related Cost Calculator 2011



PRODUCT-RELATED COSTS Number of months to analyze (will be referred to below as "the period") Total number of all vaccines administered during the period (CPT 90460) Number of additional antigens administered during the period (CPT 90461) Number of doses of vaccine in question administered during the period Hours spent ordering vaccines and monitoring vaccine storage and inventory during the period Hourly wage of staff ordering and monitoring storage and inventory PERSONNEL COSTS TO ORDER AND INVENTORY VACCINES* #DIV/0! Hours spent negotiating/monitoring vaccine purchase contracts during the period Hourly wage of staff PERSONNEL COSTS FOR NEGOTIATING/MONITORING PRICES* #DIV/0! Purchase price of refrigerator/freezer, alarm/temperature monitoring device, generators in case of power outages Cost of electricity attributable to vaccine storage refrigerator during the period #DIV/0! STORAGE COSTS** Annual cost of insurance on vaccine inventory Total value of current vaccine inventory Total value of inventory of vaccine in question INSURANCE COSTS AGAINST VACCINES ORDERED #DIV/0! Percentage of doses wasted or for which a bill is never created (i.e. forgotten, etc.) WASTAGE/UNBILLED/DENIED Reasonable annual return on investment (enter as a percentage) Average number of days from vaccine purchase to vaccine administration Days of A/R for practice (average days between appointment and payment) **OPPORTUNITY COST** PHYSICIAN TAX COST*** **BILLING/COLLECTIONS COST***** TOTAL OVERHEAD COSTS (in dollars) #DIV/0! TOTAL OVERHEAD COSTS (as a percentage of direct cost) #DIV/0!

You can use the expected energy cost advertised with the refrigerator, but keep in mind that vaccine refrigerators are generally opened much more often than your typical home refrigerator and therefore will use more electricity.

This may be a separate insurance policy or a rider on your business insurance.

You can use the Vaccine Inventory Value spreadsheet to calculate this.

AAP estimate is 5% per the AAP's Business Case. Arizona survey found an average of 2.5%.

Average rate of return of the S&P 500 from 1871 through September, 2010 is 8.8%.

**NOTE: Storage costs are automatically depreciated over 5 years in our calculations.

***NOTE: Physician tax and billing cost are calculated based on a percentage of revenue. We assume revenue for the vaccine in question is 20% above purchase price and revenue for vaccine administration is equal to the 2010 Medicare rates for 90465 and 90466.



More about this Guide

This billing resource guide was compiled by Jefferson County Public Health (JCPH), a member of the Washington State American Reinvestment & Recovery Act (ARRA) Immunization Reimbursement Project Workgroup. JCPH has billed private insurance plans for immunization services since 1991. Jean Baldwin, an RN with Multnomah County Health Department in Oregon, joined the JCPH staff that year as the CD & Immunizations Program Coordinator. She soon realized that the JCPH immunization program was providing free services that should be billed to insurance plans. Jean motivated the billing staff to set up a billing process with the three insurance plans that covered the majority of our insured families. Over the years other plans were added to our billing process; JCPH is currently billing all plans in order to maintain capacity and infrastructure and continue immunization services for Jefferson County residents. Jean is now an ARNP and the JCPH Director.

Editor: Tami Pokorny, JCPH, Port Townsend, WA

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