**ATTACHMENT – H: Data Collection Instrument – MS Word version**

Assessment of State Public Health Department’s Immunization Billing Reimbursement Projects

**Billables Project Assessment**

Welcome to the Billables Project Assessment. The current assessment will collect data about the processes and outcomes of state public health department’s immunization billing reimbursement projects.

Participation in the assessment will be voluntary and your responses are anonymous. The data and information collected will also be used to assess the value of the CDC-funded grant program and gather information to inform improvements to future CDC grants.

We estimate that it will take approximately 35 minutes to complete this assessment, and encourage you to answer all the questions. Thank you for taking the time to complete the Billables Project Assessment!

1. How do you collect patient’s health insurance information during check-in? Check all that apply.

Copy or scan of insurance card

Copy or scan of driver’s license

Written consent form

Do not know/not sure

Other, please specify

1. Does an external billing service assist your clinic with any billing efforts? (i.e. clearinghouse or 3rd party company)

Yes

No

Do not know/not sure

1. Which of the following activities does the billing service assist you with? Check all that apply.

Contracting or negotiations with insurance providers

Confirm health plan/insurance coverage prior to vaccine administration

Claims processing (submit, resubmit, etc.)

Other, please specify

1. What is the annual fee to contract this billing service? (Please include the name of the clearinghouse or company)

Cost ($)

Do not know/not sure

1. Which of the following does your clinic, either directly or through a billing service, currently bill for immunization services? Check all that apply.

Medicaid

Medicare

Commercial Insurance

Other, please specify

(**For questions 6-9 please ONLY include claim information for Medicaid or Managed Medicaid plans)**

6. Please indicate the total number of claims submitted for immunization billing to **Medicaid** plans for a recent specified amount of time (chosen by you) according to your clinics billing cycle. Please begin your count at the start of the month and include claims that were later rejected or denied.

FROM (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO (MM/DD/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Claims Total Dollars Billed 

7. During this specified timeframe, how many of the above total claims were **rejected due to a data or claim integrity problem (typo in name, incorrect date of birth, etc. )** at least once?

Number of Claims Rejected 

What percent of re-submissions are later paid? 

8. How many of the above total claims were **denied during this specified timeframe due to a specific plan contractual issue (exclusion from coverage, financial responsibility due to co-pay or deductible, duplicate service already performed, etc.)** at least once?

Number of Claims Denied  Charges Denied 

9. What is the average time frame for a **Medicaid** claim reimbursement? (i.e. from the day the claim is submitted to when the money is in your clinic’s possession)

Average Time (days) 

(**For questions 10-13 please ONLY include claim information for Medicare insurance plans)**

10. Please indicate the total number of claims submitted for immunization billing to **Medicare** plans for a recent specified amount of time (chosen by you) according to your clinics billing cycle. Please begin your count at the start of the month and include claims that were later rejected or denied.

FROM (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO (MM/DD/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Claims Total Dollars Billed 

11. During this specified timeframe, how many of the above total claims were **rejected due to a** **data or claim integrity problem (typo in name, incorrect date of birth, etc.** )at least once?

Number of Claims Rejected 

What percent of re-submissions are later paid? 

12. How many of the above total claims were **denied during this specified timeframe due to a specific plan contractual issue (exclusion from coverage, financial responsibility due to co-pay or deductible, duplicate service already performed, etc.)** at least once? Please begin your count at the start of the month.

Number of Claims Denied  Charges Denied 

13. What is the average time frame for a claim reimbursement? (i.e. from the day the claim is submitted to when the money is in your clinic’s possession)

Average Time (days) 

(**For questions 14-17 please ONLY include claim information for Commercial insurance plans)**

14. Please indicate the total number of claims submitted for immunization billing to **Commercial insurance** plans for a recent specified amount of time(chosen by you) according to your clinics billing cycle. Please begin your count at the start of the month and include claims that were later rejected or denied.

FROM (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO (MM/DD/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Claims Total Dollars Billed 

15. During this specified timeframe, how many of the above total claims were **rejected due to a** **data or claim integrity problem (typo in name, incorrect date of birth, etc.** )at least once?

Number of Claims Rejected 

What percent of re-submissions are later paid? 

16. How many of the above total claims were **denied during this specified timeframe due to a specific plan contractual issue (exclusion from coverage, financial responsibility due to co-pay or deductible, duplicate service already performed, etc.)** at least once? Please begin your count at the start of the month.

Number of Claims Denied  Charges Denied 

17. What is the average time frame for a claim reimbursement? (i.e. from the day the claim is submitted to when the money is in your clinic’s possession)

Average Time (days) 

1. Please choose the most common reason(s) for insurance claim rejects and denials **for Medicaid insurance plans**. Check all that apply.

Not a health plan beneficiary  Submitted incorrect or incomplete beneficiary information Vaccination is not a covered service

Clinic is not an approved setting for administering vaccines Patient responsibility (e.g. co-pay required, deductible not met, etc.)  Incorrect billing code Provider pre-approval or referral was not obtained Provider is not a member or is out of the network Other, please describe

1. Please choose the most common reason(s) for insurance claim rejects and denials **for Medicare insurance plans**. Check all that apply.

Not a health plan beneficiary  Submitted incorrect or incomplete beneficiary information Vaccination is not a covered service

Clinic is not an approved setting for administering vaccines Patient responsibility (e.g. co-pay required, deductible not met, etc.)  Incorrect billing code Provider pre-approval or referral was not obtained Provider is not a member or is out of the network Other, please describe

1. Please choose the three most common reason(s) for insurance claim rejects and denials **for Commercial insurance plans**. Check all that apply.

Not a health plan beneficiary  Submitted incorrect or incomplete beneficiary information Vaccination is not a covered service

Clinic is not an approved setting for administering vaccines Patient responsibility (e.g. co-pay required, deductible not met, etc.)  Incorrect billing code Provider pre-approval or referral was not obtained Provider is not a member or is out of the network Other, please describe

1. What is your clinic’s procedure for resubmitting rejected claims?

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1. Is your clinic a VFC (Vaccines for Children Program) provider?

Yes

No

Do not know/not sure

1. Has your clinic experienced any change in the number of VFC eligible children being immunized in your clinic in the past year?

Yes

No

Do not know/not sure

If answered yes, please describe the change.

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1. Does your clinic charge a vaccine administration fee for state-supplied vaccine, when applicable?

Yes

No

Do not know/not sure

1. Does your clinic request payment from under or uninsured patients (e.g administration fee for under or underinsured patients)?

Yes

No

Do not know/not sure

1. Does your clinic have a policy on collecting copays and deductibles?

Yes

No

Do not know/not sure

If answered yes, please describe the policy or attach a copy.

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1. Does your clinic balance bill a patient when a high deductible insurance plan only applies payment to the patient’s deductible or co-pay?

Yes

No

Do not know/not sure

If answered yes, please describe how you are requesting payment from patients and the average amount you write-off due to failed collection.

1. Do you have a hardship policy for patients who have no/limited means to pay for immunization in full? Please provide a copy of your agency’s hardship policy if applicable.

Yes

No

Do not know/not sure

1. Which of the following methods were used to request payment from patients who have no/limited means to pay for immunizations? Check all that apply.

Donation (amount up to the patient)

Sliding fee scale payment (charges varied according to ability to pay)

Fixed payment (charged exactly what was owed)

Don’t collect payments from patients

Do not know/not sure

Other/combination, please describe

1. Do you charge an administration fee for immunizations given in your clinic?

Yes

No

Do not know/not sure

If answered yes, please provide a list of these charges

1. What vaccines do you carry in private stock? Please attach an itemized list including the types of vaccines and number of doses of your private stock.

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1. Where are the funds generated to purchase your private stock? Check all that apply.

State funding

Federal funding

Funds collected from immunization reimbursement

Third party vendor/company

Do not know/not sure

Other, please describe

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1. During the last fiscal year, how much has your clinic spent on purchasing private stock vaccine?

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1. At what percentage rate does your clinic currently collect from immunization reimbursement? (Please attach the most recent financial report regarding the reimbursement rates for your clinic)

20 percent or below

20-40 percent

40-60 percent

60-80 percent

80 percent or above

Do not know/not sure

1. Please choose the most common barrier to receiving 100 % immunization reimbursement for your clinic?

No contract with one or more insurance plan that covers patients

Reimbursement rate is too lowClinic does not have the infrastructure to completely bill Other, please describe

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1. Where are the funds collected from immunization reimbursement reinvested? Check all that apply.

State fund

Clinic Budget

Do not know/not sure

Other, please describe

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1. What other services does your clinic currently bill for? Check all that apply.

STD/HIV

Family planning

Do not know/not sure

Other, please describe

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1. Is there current legislation in your state that has **supported** your billing program with contracting or increasing reimbursement? If so, please provide a brief detail of the legislation and the bill number.
2. Is there current legislation in your state that has **hindered** your billing program with contracting or increasing reimbursement? If so, please provide a brief detail of the legislation and the bill number.
3. Has your clinic billed any self-insured health plans and received reimbursement?

Yes

No

Do not know/not sure

If answered yes, please list the name of the self-insured plan.

1. Is your clinic credentialed by any insurance plan(s)?

Yes

No

Do not know/not sure

If answered yes, please list the name of the insurance plan(s), which you currently are credentialed.

1. What is the number one barrier to not being able to establish a contract with commercial insurance plans?

Not being able to successfully get credentialed

Denied because of too many providers in the area Unable to connect with the insurance plan to establish a working relationship

Other, please describe

1. Please list each insurance plan that has been billed by your clinic for immunizations in the last fiscal year. Please indicate if a contract was established for reimbursement by placing an asterisk (\*) next to the insurance plan. **(Please see page 10 for optional recording space)**.
2. Please feel free to share any other relevant information related to billing for immunization services in the space below.

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| **Health Plan/Insurance Provider** | **Check box ONLY if a contract has been established.** |
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