Form Approved
OMB No. 0920-0879
Exp. Date 03/31/2014

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

2. 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

3. 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

4. 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

5. 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) ☐

18. 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

    ☐

19. 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

    ☐

20. 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

21. What is your clinic's procedure for resubmitting rejected claims?

22. Is your clinic a VFC (Vaccines for Children Program) provider?
    - [ ] Yes
    - [ ] No
    - [ ] Do not know/not sure

23. 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.

24. Does your clinic charge a vaccine administration fee for state-supplied vaccine, when applicable?
    - [ ] Yes
    - [ ] No
    - [ ] Do not know/not sure

25. 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

26. 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.

27. 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.

28. 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

29. 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

30. 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

31. 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.

32. 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

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

34. 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

35. 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 low
- ☐ Clinic does not have the infrastructure to completely bill
- ☐ Other, please describe

36. 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

37. 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

38. 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.

39. 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.

40. 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.

41. 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.

42. 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

43. 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)**.

44. Please feel free to share any other relevant information related to billing for immunization services in the space below.

Health Plan/Insurance Provider	Check box ONLY if a contract has been established.
1.	☐
2.	☐
3.	☐
4.	☐
5.	☐
6.	☐
7.	☐
8.	☐
9.	☐
10.	☐
11.	☐
12.	☐
13.	☐
14.	☐
15.	☐
16.	☐
17.	☐
18.	☐
19.	☐