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

ATTACHMENT – G: Data Collection Instrument - Web version

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

Billables Project Assessment

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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!

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0879).

+ Add Question ▼

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0879).

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[SURVEY PREVIEW MODE] Billables Project Assessment Survey

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?

- ○ Yes
- ○ No
- ○ Do not know/not sure

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

- ☐ Contracting or negotiations with insurance providers
- ☐ Claims processing (submit, resubmit, etc.)
- ☐ Confirm health plan/insurance coverage prior to vaccine administration
- ☐ Other (please specify)

4. What is the annual fee to contract this billing service?

- ○ Do not know/not sure
- ○ Annual Fee ($)/ (Please include the name of the clearinghouse or company)

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5. Which of the following does your clinic, either directly or through a billing service, currently bill for immunization services?

	Yes	No
Medicaid	○	○
Medicare	○	○
Commercial Insurance	○	○

Other (please specify)

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6. For this question please ONLY include claim information for Medicaid or Managed Medicaid plans.

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.

Date Period: From(MM/DD/YYYY)-To(MM/DD/YYYY)

Total claims billed during this time period?

Total dollars ($) billed during this time period?

7. For this question please ONLY include claim information for Medicaid or Managed Medicaid plans.

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?

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8. For this question please ONLY include claim information for Medicaid or Managed Medicaid plans.

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. For this question please ONLY include claim information for Medicaid or Managed Medicaid plans.

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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)

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10. For this question please ONLY include claim information for Medicare plans.

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.

Date Period: From(MM/DD/YYYY)-To(MM/DD/YYYY)

Total claims billed during this time period?

Total dollars ($) billed during this time period?

11. For this question please ONLY include claim information for Medicare plans.

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?

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12. For this question please ONLY include claim information for Medicare plans.

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

13. For this question please ONLY include claim information for Medicare plans.

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)

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6ss.pdf - Adobe Acrobat Pro

14. For this question please ONLY include claim information for Commerical insurance plans.

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.

Date Period: From(MM/DD/YYYY)-To(MM/DD/YYYY)

Total claims billed during this time period?

Total dollars ($) billed during this time period?

15. For this question please ONLY include claim information for Commerical insurance plans.

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?

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16. For this question please ONLY include claim information for Commerical insurance plans.

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

17. For this question please ONLY include claim information for Commerical insurance plans.

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)

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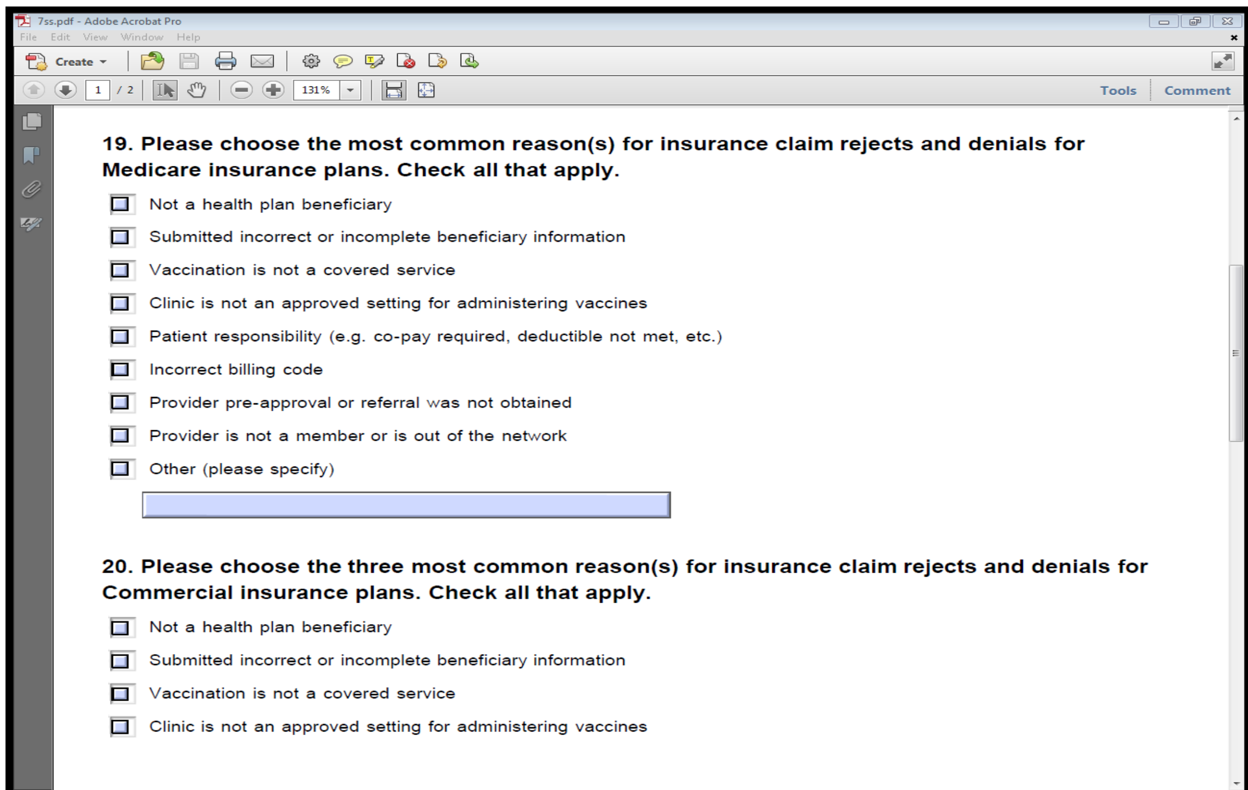
18. Please choose the most common reason(s) for insurance claim rejects and denials for Medicaid insurance plans. Check all that apply.

- ☐ 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 specify)

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



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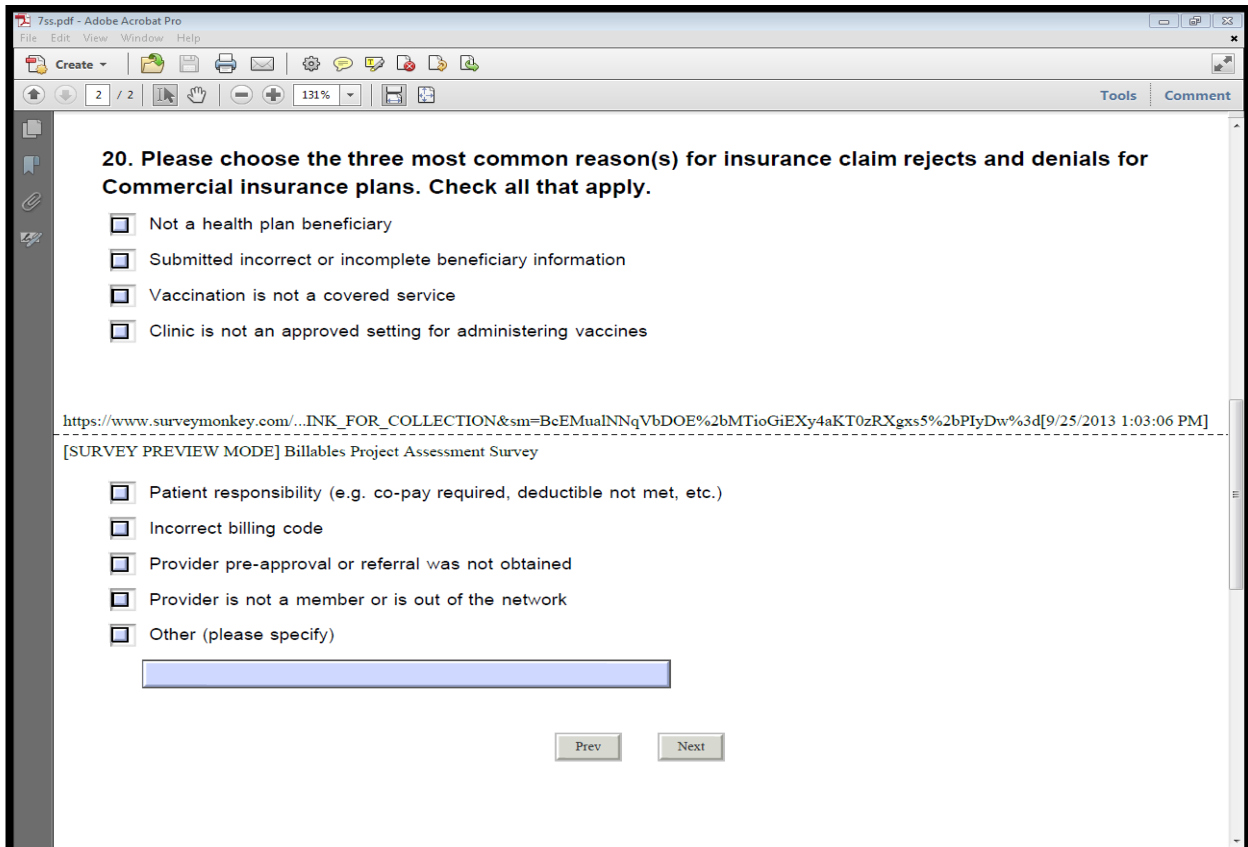
19. Please choose the most common reason(s) for insurance claim rejects and denials for Medicare insurance plans. Check all that apply.

- ☐ 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 specify)

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



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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

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- ☐ 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 specify)

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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

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

- Yes
- No
- Do not know/not sure

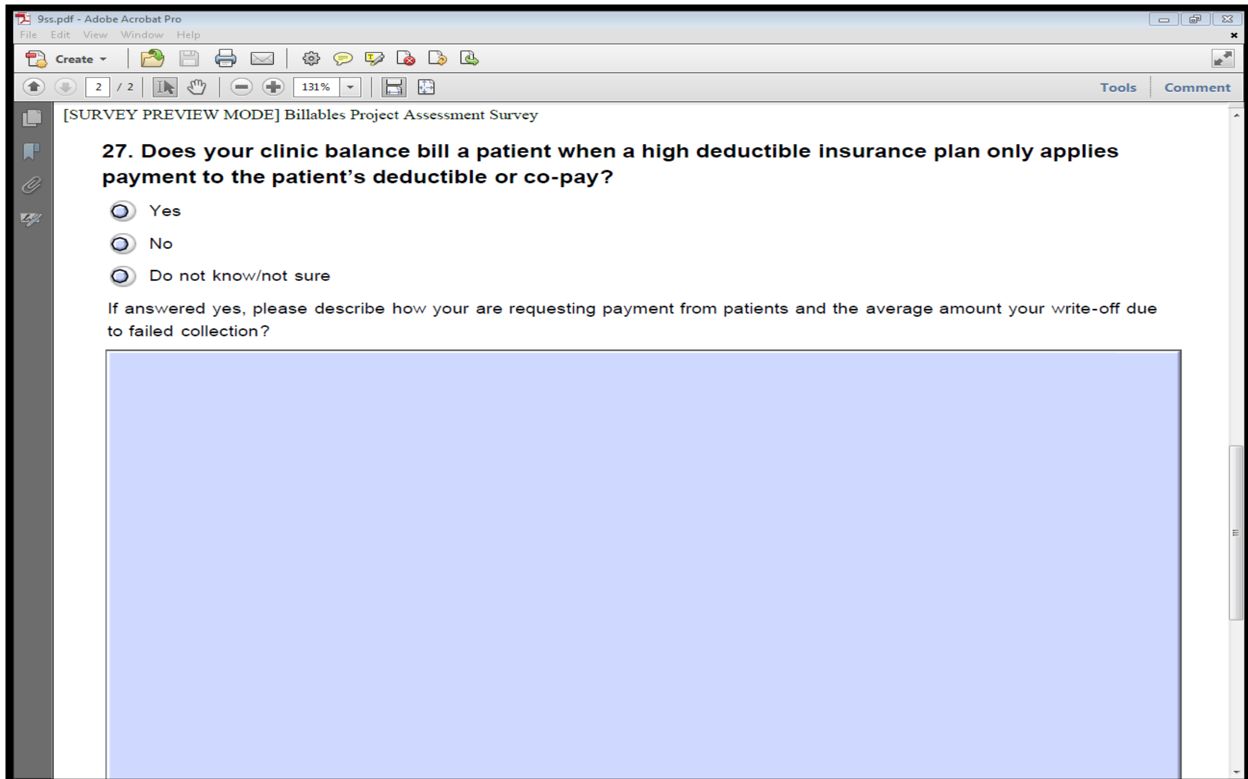
25. Does your clinic request payment from under or uninsured patients (e.g administration fee for under or underinsured patients)?

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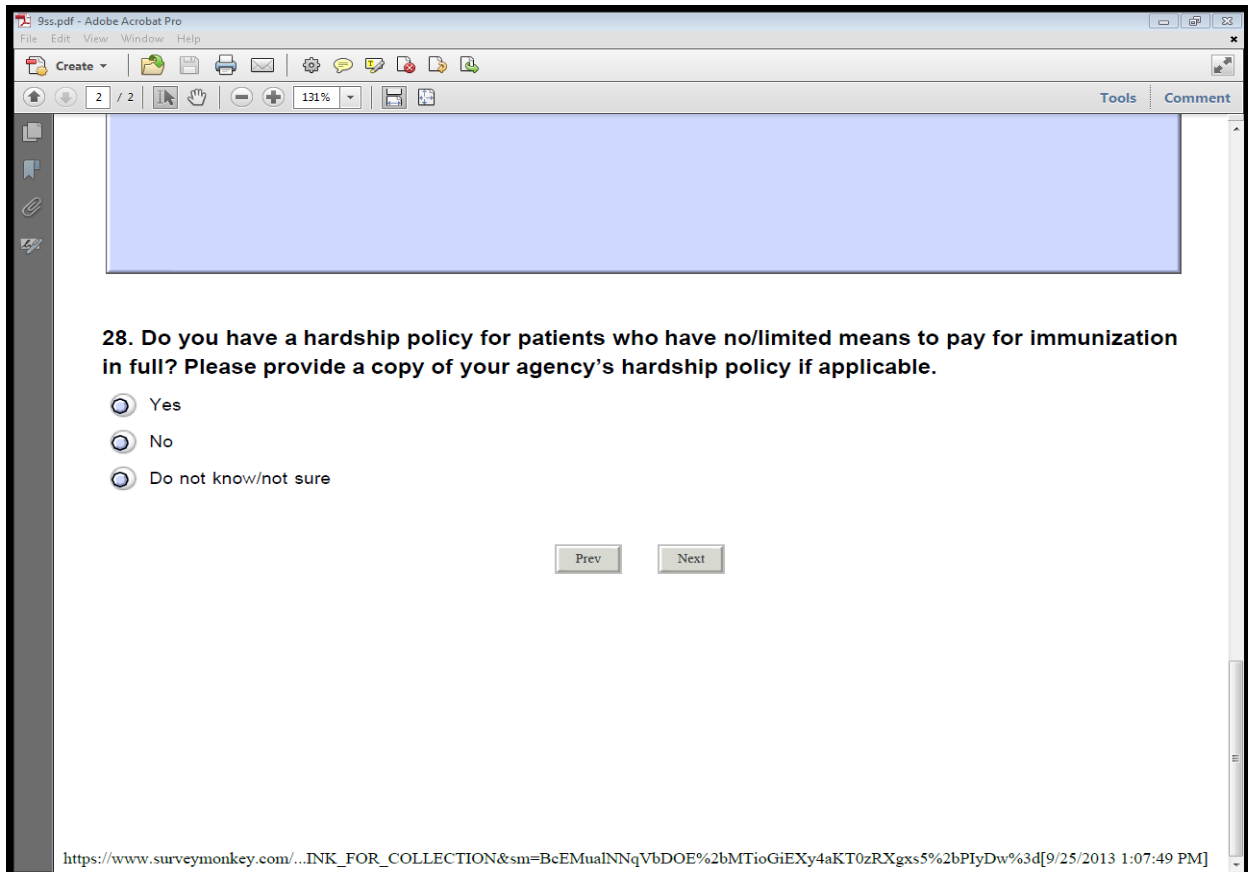
27. Does your clinic balance bill a patient when a high deductible insurance plan only applies payment to the patient's deductible or co-pay?

- Yes
- No
- Do not know/not sure

If answered yes, please describe how your are requesting payment from patients and the average amount your 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

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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 (please specify)

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.

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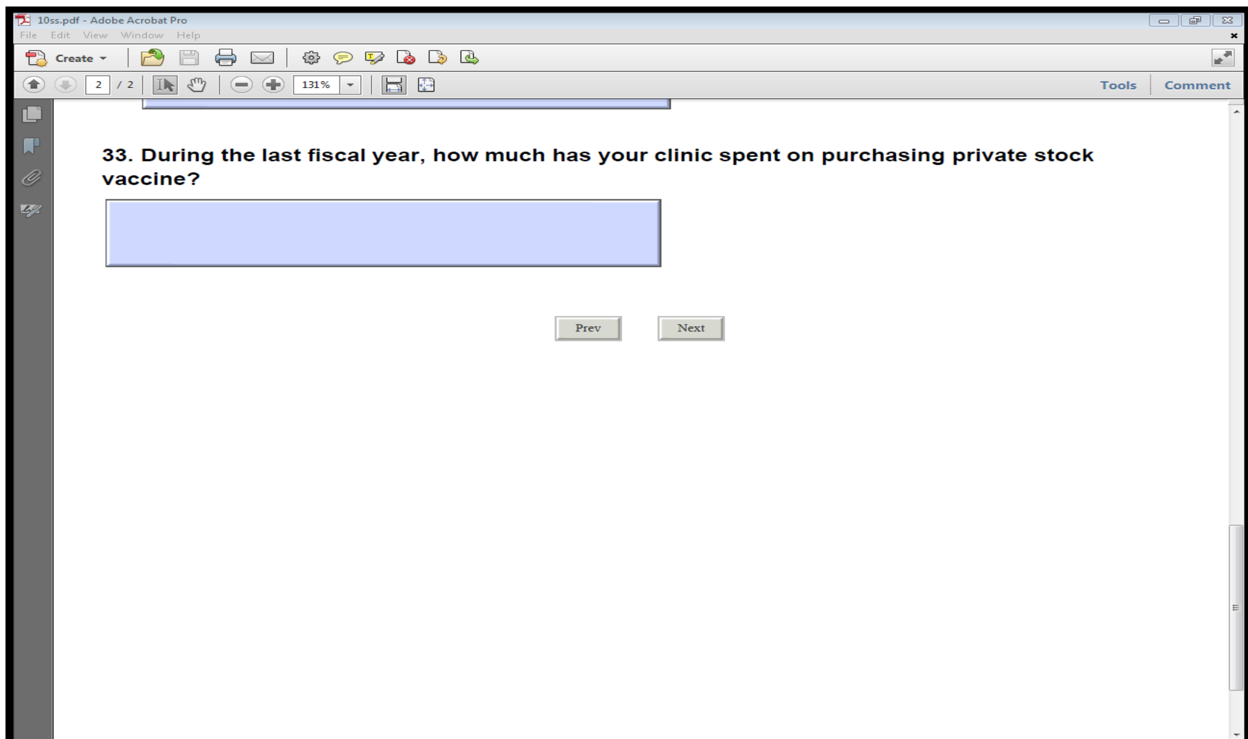
31. What vaccines do you carry in private stock? Please attach an itemized list including the types of vaccines and number of doses of your private stock.

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 specify)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33. During the last fiscal year, how much has your clinic spent on purchasing private stock vaccine?
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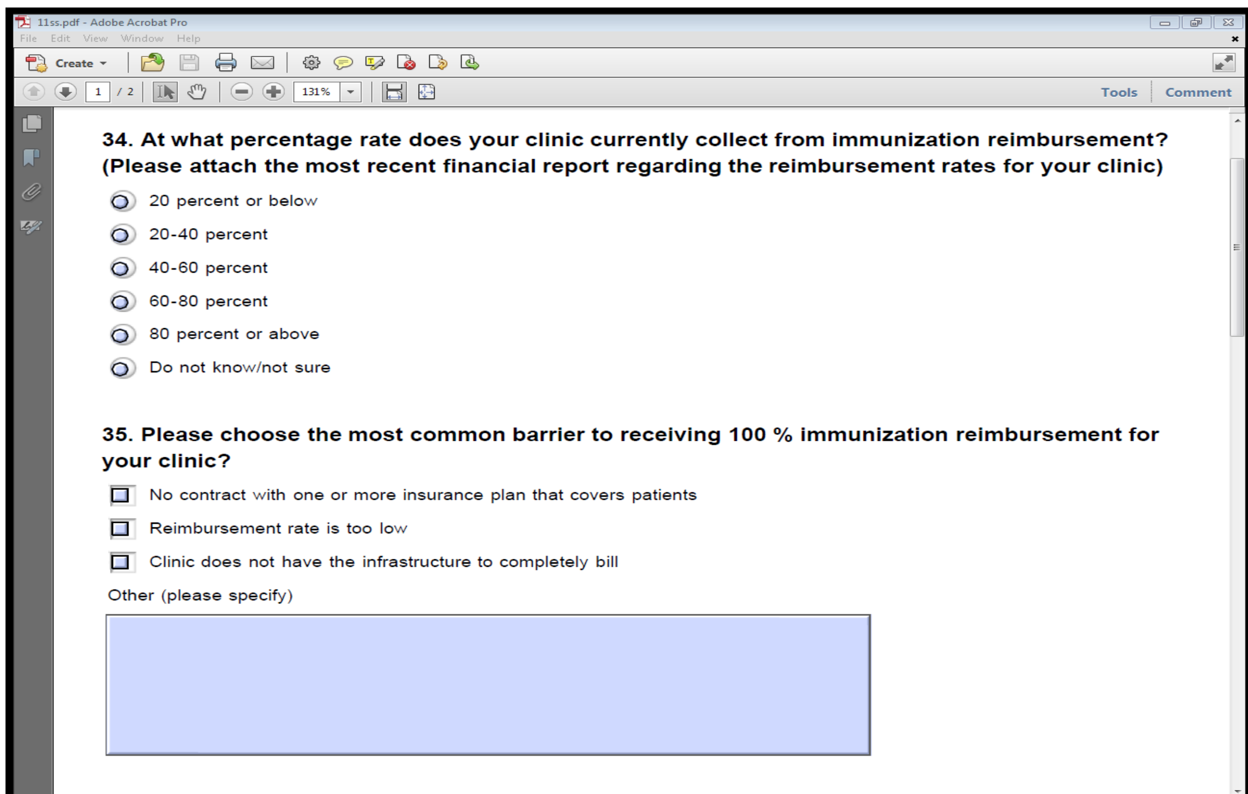
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34. At what percentage rate does your clinic currently collect from immunization reimbursement? (Please attach the most recent financial report regarding the reimbursement rates for your clinic)
20 percent or below
20-40 percent
40-60 percent
60-80 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 specify)

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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 specify)

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 specify)

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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-insuranced plan(s).

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- Yes
- No
- Do not know/not sure

If answered yes, please list the name of the self-insuranced plan(s).

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.

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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 specify)

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.

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