

Prevention and Public Health Fund (PPHF) Program Area 3

Last Updated 2/21/2012

Project Objectives

1. Better understand local health department (LHD) billing capabilities.
2. Identify and address the barriers for LHDs who want to implement or expand billing programs.
3. Estimate the potential return on investment.
4. Demonstrate how revenue streams may be expanded through billing immunization services for privately insured clients.
5. Develop a strategic plan.
6. Assess, then implement or expand LHD billing of private insurers for immunization services.
7. Pilot test, assess and refine the strategic plan.

Known Barriers

1. **Kansas Statutes:** The lack of Kansas statutes specifically allowing registered nurse (RN) and licensed practical nurse (LPN) billing for vaccine administration.
2. **Federal Program Changes:** Changes in the Vaccines for Children (VFC) program rules and use of “317 funds” have made it more difficult for LHDs to provide services for all patients within the community.
3. **Credentialing:** LHD providers meeting health plan requirements for provider credentialing. In particular, most LHDs lack of a full time medical doctor (MD) onsite.
4. **Network Participation Status:** Participating versus non-participating provider status of LHDs impacts reimbursement for immunization services.
5. **Network Participation Status:** When LHDs are non-participating, there are instances when the LHD bills insurance for the service, but the insurance payment is mailed to the client. LHDs are rarely able to recover the payment from the client.
6. **Start-up Cost:** The application costs for LHDs to apply to be a network provider.
7. **Start-up Cost:** Costs associated with building a private vaccine stock.
8. **Start-up Cost:** Other costs to implement and maintain billing programs.
9. **Start-up Cost:** Some LHDs do not have adequate funding for computer resources to support billing.
10. **Start-up Cost:** Some LHDs have experienced problems getting access to affordable billing software.

11. **Start-up Costs:** In some counties, the low demand for private stock vaccines in the LHD setting make it difficult to justify the cost.
12. **Start-up Costs:** LHD-specific resource needs and the ability to sustain services.
13. **Training Needs:** There is a lack of training resources specific to LHD billing concerns.
14. **Training Needs:** A LHD billing manual was developed several years ago by volunteer members of the Kansas Association of Local Health Departments. However, there were no resources to maintain this resource and the information is now out of date.
15. **Training Needs:** The regional billing groups are a good resource in some regions and are less helpful in others. When the LHDs in a region have differing systems, these groups may not be as helpful.
16. **Training Needs:** There is a billing list serve through the Kansas Association of Local Health Departments (KALHD), but the membership is limited to billing staff at the LHDs. It would help to expand this resource to allow the insurance companies to participate in the discussions.
17. **Training Needs:** LHDs are rarely able to hire qualified coders.
18. **Training Needs:** LHD billing staff reported it is difficult to keep up with billing process changes.
19. **Training Needs:** Some LHDs have difficulty with the accuracy of the clinical data entry in the electronic medical record (EMR) system, which creates problems for billing staff.
20. **Training Needs:** LHDs reported problems with interpreting insurance company rejection codes.
21. **Training Needs:** For some LHDs, it is still a guessing game regarding the correct codes to use on claims, and they may go through a lot of trial and error to get it right or they may give up because they are not having success.
22. **Training Needs:** For some LHDs, it is still a guessing game regarding possible reimbursement levels for immunization services. Rather than setting the amount billed based on the cost to provide the service, they may bill the Medicaid allowed amount because that is what they know they can get paid based on experience. Medicaid reimbursement is often low compared to private insurance, so the LHDs may not be getting all the reimbursement they could receive for immunization services.
23. **Training Needs:** The federally mandated implementation of ICD-10 coding in 2013 may impact codes required on immunization claims.
24. **Insurance Requirements:** The coding requirements for immunizations vary between insurance companies.
25. **Insurance Requirements:** A single insurance company can have multiple plans with each plan having differing coverage rules for immunization services.

26. **Insurance Requirements:** LHDs report problems obtaining consistent and accurate answers to billing questions. Different provider representatives within the same insurance company may provide conflicting answers.
27. **Insurance Requirements:** Insurance companies report having made changes to their internal policies that should allow LHDs to enroll more easily. However, this information has not been broadly communicated to the LHDs.
28. **Insurance Requirements:** Payments from the insurance company to the LHD may be misdirected within the county infrastructure. Some counties have only one tax identification number (ID), but have multiple providers (LHD and ambulance service as an example). Each provider is required to have a National Provider Indicator (NPI) that is required to be included on electronic claims, but if the insurance company processes based on the Tax ID, then the payments are not easily tied back to the appropriate department.
29. **Insurance Requirements:** Another issue relating to insurance systems that process based on Tax ID is that access to electronic resources is sometimes limited to one login account per Tax ID.
30. **Insurance Requirements:** The insurance company may require the enrollment fee be submitted using a cashier's check. Some county's policies do not allow use of cashier's checks.
31. **Client Knowledge:** Clients rarely know the details of their insurance coverage. In some cases, clients are not aware if they have coverage at all.
32. **Client Knowledge:** Public misperceptions that LHD services are free. One result is that clients do not realize the need to bring their insurance information when seeking services at the LHD.
33. **Contact Information:** LHDs have difficulty identifying the best contact at each insurance company.
34. **Contact Information:** Insurance companies have difficulty identifying the best contact at each LHD. For the insurance companies, identifying staff with contracting authority is the biggest challenge.
35. **Billing Capabilities:** The inability of some LHDs to bill electronically for services.
36. **Local Governance:** High staff turnover and leadership changes within the LHD and county government can be a barrier in implementing billing programs.
37. **Local Governance:** There appears to be an organizational disconnect within some LHDs. The billing staff may perceive they do not have the authority to make decisions while the administrator may perceive the billing staff is empowered to make billing-related decisions.

Potential Opportunities

1. The stakeholder group identified an interest in convening two subgroups to address:

- Updating the LHD billing manual.
 - Defining LHD billing staff training needs.
2. Multi-jurisdictional relationships within existing emergency preparedness regions may be helpful in developing cost effective billing programs.
 3. If the existing LHD billing list serve membership could be expanded, this existing resource could be more useful to the participants.
 4. BCBS of KS offers an online “PCA billing system” free of charge to contracted providers.
 5. BCBS of KC shared information about a new system called “Availity.” This system may be available to LHDs free of charge, and could be used by LHDs to obtain accurate and timely insurance coverage data for multiple participating insurance companies at the point of service.
 6. EDI Midwest Commercial Clearinghouse is a local and relatively low cost option for LHDs to consider for claims conversion services.
 7. Some LHDs currently partner with other county agencies (EMS providers) or with other local providers (hospitals) to centralize their billing functions. This may be a model that could be considered by other LHD providers to enhance billing infrastructure and return on investment for third party billing.
 8. Federal health care reform calls for increased coverage of immunization services and a reduction in the uninsured population, which would enhance the potential return on investment for expanded immunization billing by LHDs.
 9. Existing billing resources available through KALHD may be a useful starting point for development of updated billing resources and training.
 10. Some Kansas LHD billers have a lot of billing experience and success (superbillers). These billers have been willing to mentor staff at other LHDs in the past and could be a good resource in developing updated billing resources and training.
 11. Public health accreditation may have a positive impact on LHD billing practices, since there is likely to be a move toward further centralization to meet accreditation requirements.
 12. The opportunity may exist to collaborate with local health department family planning in development of billing training materials.