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California's Innovative Immunization Billing Project Plan



Kern County Public Health Services

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Disclaimer

This document represents a collective effort to provide a guide on billing health insurance for Public Health services. Billing processes and websites change frequently. Information provided in this document was current at the time it was collected.

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BACKGROUND

Purpose of Project

Kern County was an ideal location to partner with the State of California in developing an innovative reimbursement plan for immunizations in public health department clinics.

Located in Central California, Kern County is the third largest county in California by land mass and the tenth most populous county with 839,631 residents. The Kern County Public Health Services Department (KCPHSD) operates 13 clinic sites throughout Kern County. These sites provide immunizations to children utilizing Vaccines for Children (VFC) and 317 purchased vaccines. The policy of the department is to provide immunizations to all children who present at the clinic to



avoid missed vaccination opportunities. Many residents rely on public health clinics to receive preventative services and vaccines for a variety of reasons. In some areas of the County, access to a primary care physician is limited. Transportation also is a barrier to receiving medical care. Even privately insured residents often utilize public health clinics for convenience or due to the inability to quickly get appointments with their private provider. As the number of recommended vaccines has increased, some of the private providers can no longer financially carry the inventory necessary to properly immunize their patients. For example, one private pediatrician refers all clients to the public health department for vaccines, and prior to this project, the department's billing mechanism only allowed for billing of the administration fee for these clients.

Prior to this project KCPHSD provided limited billing for services provided in the clinics. The primary entities which were billed were Medi-Cal, Child Health and Disability Prevention (CHDP), and the two local Medi-Cal managed health care plans. The department had attempted to bill private insurance in the past, but there were many barriers to implementing successful private insurance billing practices. The primary obstacles to billing included not being a preferred provider with the various insurance companies and the department's electronic billing

system not being properly set up to bill private insurance. Reduced staffing levels and limited staff knowledge about insurance billing also contributed to these obstacles.

The department utilizes an electronic patient care management system purchased from Netsmart, Inc. called Insight. This is a table driven electronic system that has the capability of doing medical billing but the tables must be set up correctly for billing to be successful. This had not happened prior to this project because of limited staff resources and deficiencies in insurance coding knowledge. Staff resources were also limited for correcting medical billing errors, so some claims eligible for payment went unpaid. For these reasons, this project provided an opportunity to work on reducing these barriers/obstacles to successful billing and create a model that can be taken to other counties for implementation.

California Vaccine Program

In California, local health departments (LHDs) are considered safety net providers for the provision of childhood immunizations for the under and uninsured population within each



jurisdiction. To increase immunization rates within the jurisdictions and prevent missed opportunities to vaccinate, LHDs are able to provide all childhood recommended by ACIP (Advisory Committee on Immunization Practices) to all children seeking vaccination, regardless of insurance status. LHDs are able to provide this service because they receive childhood vaccines from a combination of funding sources, including State General, Federal (317), and Vaccines for Children (VFC) Program funds. To encourage the provision of comprehensive primary health care, LHDs are charged with referring insured children with a primary care provider/medical home back to their provider or assisting with the location of a medical home (Policy for Provision of State-Funded Vaccines to Privately Insured Patients by Local Health Department Jurisdictions, Effective Date: January 1, 2010, Revised Date: August 3, 2010).

VFC Program

The VFC program was established by an act of Congress in 1993 and helps families by providing free vaccines to doctors who serve eligible children aged 0 through 18 years. The VFC program is administered at the national level by the U.S. Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order routine vaccines through their state VFC Program at no cost. This allows them to provide routine immunizations to eligible children without high out-of-pocket costs, to patients.

The California VFC Program is managed by the California Department of Public Health, Immunization Branch. Children eligible for vaccine supplied through the VFC Program must be eligible for Medi-Cal/CHDP (Child Health Disability Prevention), uninsured, or of American Indian/Alaska Native descent.

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. Any California-licensed M.D., D.O., or health care organization serving VFC-eligible children can become a VFC provider. Providers receive vaccine after completing an enrollment application and sending it to the VFC program. Before vaccine can be shipped, a VFC Field Representative will make a site visit, review the program requirements with the provider and staff, and verify that they are in compliance with all VFC requirements. After a provider is approved, they are able to order vaccines monthly, bimonthly, or quarterly depending on the size of the practice. The vaccines are shipped directly to the provider's office by the national distributor, McKesson Specialty.

VFC providers are required to comply with CDC's Standards for Pediatric Immunization Practices. Providers are visited periodically by a VFC Field Representative who conducts a Quality Assurance Review (QAR). During the QAR, the representative assesses the provider's compliance with CDC's standards as well as other VFC program requirements. Providers must record the patient's eligibility status in his/her chart. Children who have health insurance that does not cover immunizations may receive VFC vaccines, but only at federally qualified health centers or rural health clinics. Children enrolled in the Healthy Families program (California's Children's Health Insurance Plan) are not VFC-eligible. Enrollment in Medi-Cal or CHDP is not a requirement for being a VFC provider. Providers are not required to accept children into their practice solely because the children are eligible for the VFC Program (How the VFC Program Works <http://eziz.org/vfc/overview/>). At the inception of the VFC program in California in the mid to late 1990's only private providers were serviced by the program.

Prior to 2007, LHDs ordered vaccine for their clinics directly through the State Immunization Branch on a quarterly basis. Vaccines were directly shipped from the state depot to the LHDs, of whom; a vast majority also had depots. Staff in the LHDs would then distribute the vaccine to their satellite clinics. Kern County, has eleven satellite clinics, some of which are located up to two hours from the main office (depot) where the vaccines were received and stored. Staff in the satellite clinics had the ability to order vaccine (from the main office depot) on a monthly basis. The vaccine would then be packaged and transported by nursing staff to those destinations. Vaccine inventory and accountability reports were completed by each site and

reported to the local immunization county program on a monthly basis, which then submitted a monthly report to the State Immunization Branch.

In 2007, California changed how LHDs ordered and accounted for their vaccines. All LHD sites were switched to ordering and accounting for their vaccine usage through the VFC program. LHDs were instructed to discontinue their depots and to have vaccine shipped directly to each satellite clinic. In Kern, each satellite office/clinic was enrolled in the VFC program, given a pin number and trained on how to properly order and account for the vaccine received at their site. Each clinic was also given an order frequency timetable which is based on the size of the clinic and the number of vaccines used per year. Each clinic either orders monthly, bi-monthly or quarterly. This practice continues today with LHDs and private providers totaling approximately 4500 VFC providers in the state.

In Kern County, as with most counties in the state, the vast majority of vaccinations are administered by private providers. The local health department has always served as a safety net provider for those with and without insurance at minimal cost. Over the last five years, there has been an increase in the number of clients presenting for immunization services, from a low of 9,000 clinic visits in 2007 to a high of over 24,000 visits in 2011. In 2007, 20,492 doses of vaccine were administered to children aged 0 through 18 years, compared to 40,451 doses as of December 13, 2011.

California Population Breakdown

California is the most populous state in the nation with 37,349,363 residents as of the 2010 American Community Survey. It is 49.7% male and 50.3% female with a median age of 35.2 years. A full quarter of the population is under the age of 18 years and 11.4% is over the age of 65 years. Over a third (37.7%) of the state identify as Hispanic or Latino while 40.0% identify as non-Hispanic White. Non-Hispanic Asian was selected by 12.9% of residents and 5.8% identify as non-Hispanic Black or African American. Only 0.4% of residents identify as American Indian and Alaskan Native and 0.4% identify as Native Hawaiian and Pacific Islander. Only 0.2% identify as some other race while 2.6% identify with two or more races.

Of those aged 25 years or older, 80.7% of the population have completed high school or higher. More than 30% of the population have a bachelor's degree or higher. While there are provisions for minors to work in certain industries, in general, Californians must be at least 16 years of age to work. Of the population 16 years of age and older, 64.3% are part of the labor force. Of the 18,625,515 people in the civilian labor force, 12.8% are unemployed. The median household income is \$57,708 and the per capita income is \$27,353. In California, 15.8% of residents have incomes below the federal poverty level; of those less than 18 years of age, 22.0% live below the poverty level.

Of the civilian, non-institutionalized population, 81.5% have health insurance coverage. Over 6.8 million Californians have no health insurance coverage. Of those with health insurance, 54.4% receive coverage through an employer, 17.7% are covered by Medicaid (Medi-Cal), and 7.5% are covered by Medicare. Of those under the age of 18 years, 9.0% have no health insurance coverage.

The median value of owner-occupied housing is \$370,900 while the median cost of rent is \$1,163 per month. More than a quarter of residents (27.2%) are foreign-born, of which 45.6% are naturalized citizens. Most foreign-born residents (54.0%) were born in Latin American countries, followed by 35.9% of foreign-born residents who were born in Asia. After English, Spanish is the most commonly used language with 28.9% of residents speaking Spanish at home.

Kern County Population Breakdown

Kern County is the tenth most populous county with 839,631 residents and is the third largest county in California by land mass. The population is 51.6% male and 48.4% female. It



has a slightly younger population compared to the rest of the state with a median age of 30.7 years. Nearly a third of the population (30.2%) is under the age of 18 years and 9.0% is over the age of 65 years. Nearly half of Kern County residents (49.3%) identify as Hispanic or Latino, while non-Hispanic White makes up 38.4% of the population. Only 3.7% of Kern County residents identify as non-Hispanic Asian and

5.4% of residents identify as non-Hispanic Black or African American. American Indian and Alaskan Native was selected by 0.8% of the population and 0.1% selected Native Hawaiian and Pacific Islander. Only 0.2% of residents selected some other race and 2.1% identify with two or more races.

Of those over the age of 25 years, 71.3% completed high school. Compared to California, Kern County residents are half as likely to obtain higher education as only 15.0% of the population report having a bachelor's degree or higher. Of the population aged 16 years and over, 59.0% are in the labor force. Of the 363,703 residents in the civilian labor force, 14.6% are unemployed. Approximately 15.5% of Kern County residents work in the agriculture, forestry, fishing and hunting, and mining industries, compared to only 2.4% of Californians. The median household income is \$45,524 and the per capita income is \$19,077. In Kern County, 21.2% of residents have incomes below the federal poverty level; of those under age 18 years, 30.5% live below the federal poverty level. Of the civilian non-institutionalized population, 77.8% have health insurance coverage. Another 180,290 residents have no health insurance coverage. Of those insured, 48.7% have health insurance provided by an employer, 27.5% are covered by Medicaid (Medi-Cal), and 11.8% are covered by Medicare. Of those under the age of 18 years, 11.4% have no health insurance coverage. The median value of owner-occupied housing is \$164,200 while the median cost of rent is \$821 per month. One in five Kern County residents

(20.7%) are foreign-born, of which 29.4% are naturalized U.S. citizens. The majority of foreign-born residents (80.8%) were born in Latin American countries followed by Asia where 14.6% were born. Other than English, Spanish is the mostly commonly used language with 35.9% of residents speaking Spanish at home. (Source: US Census Bureau, 2010 American Community Survey 1-Year Estimates.)

PLANNING PROCESS

Stakeholders

A diverse group of stakeholders have been involved with the Innovative Immunization Billing Project. On the local level (Kern County)—Public Health, the Board of Supervisors,



County Administrative Office, County Auditor's office, Kern Medical Center (local county hospital) and County Mental Health-- have all been involved in the development process. Both local Medi-Cal managed care systems (Health Net

and Kern Family Health Systems) have been actively involved in the process. Strong liaison contacts have been established with the major private insurance companies that were determined through survey and analysis of past data to be the most common types of insurance clients use in Kern's health department clinics. These companies are Anthem Blue Cross, Blue Shield, United Healthcare, Aetna, Cigna, Humana, Self-Insured Schools of California (SISC), and Managed Care Systems. Liaison contacts have also been established with Medi-Cal and Medicare. At the State level, several program areas within the California State Department of Public Health and Governor Jerry Brown's office are routinely briefed on the progress of the plan and are very interested in assisting towards successful implementation. A contact has also been established in each of the county and city health jurisdictions. In addition, Netsmart, Inc., owner of a Public Health electronic patient management system (INSIGHT), has been a partner in this process. The insurance expert hired by Kern County was asked by the company to facilitate a billing users group once a month to help the company and other users across the country to make improvements to the software and increase efficiency with billing.

Capacity

State Analysis

Two surveys were conducted with the 58 county and 3 city local health jurisdictions in California. The purpose of the first survey was to identify a county contact for this project and to determine what type of clinic services are provided, what kind of fee schedule is in place, and if any billing is being done. The second survey was done 6 to 8 months later and more specific questions were asked relating to billing, existing resources, and current processes. Initial results of these surveys show the following breakdown for billing services already in place:

- Only 11% of the jurisdictions are currently billing private insurance, Medi-Cal, and Medicare.
- 31% of the jurisdictions complete Medicare roster billing only, the majority of these were for influenza vaccine.
- 18% of the jurisdictions complete Medicare roster billing and bill Medi-Cal.
- 7% of the jurisdictions bill Medi-Cal only.
- 20% of the jurisdiction complete no billing and provide services for free or a nominal administration fee.
- 13% of the jurisdictions provide no clinic services at all.

Initial analysis of clinical services currently provided by the jurisdictions is as follows:

- 10% of the jurisdictions provide immunizations only.
- 7% of the jurisdictions provide immunizations and one other service (i.e., family planning, TB clinic, STD services, HIV services, prenatal services).
- 25% of the jurisdictions provide immunizations and two other services.
- 38% of the jurisdictions provide immunizations and three or more other services.
- 8% of the jurisdictions provide primary care services including immunizations.

Understanding the landscape of services provided throughout the state is important in assessing billing capacity and interest by each of the jurisdictions to take on this type of task. When additional services are provided, the potential revenue that can be generated by each jurisdiction increases. See maps of services and billing patterns for California on the next two pages.

Mapping of County Services

As of 3/2/11



Types of Billing Performed by California Local Health Jurisdictions

3/2/11

- Bills private health insurance
- Medi-Cal, Medicare
- Bills Medi-Cal Only
- Bills Medicare Only
- No Billing
- No Services

CALIFORNIA'S 58 COUNTIES



The State also gained further insight into 317-vaccine usage in recent months. A California law was passed in 2010 requiring all students entering 7th grade through 12th grade to have documentation of a Tdap vaccine in order to attend school for the 2011/12 school year. This requirement taxed most of the LHDs because many of these students relied on public health to receive this vaccine. At the same time due to budget cuts, the State allocation of 317 funds for vaccine was reduced. This caused increased tracking of usage of non-VFC vaccine. The LHDs were required to report vaccine usage by VFC administered doses vs. 317 administered doses.

CALIFORNIA TDAP USAGE REPORT						
# of Counties Reporting		317 ADMINISTERED	VFC ADMINISTERED	% 317 ADMINISTERED	% VFC Administered	TOTAL ADMINISTERED
55	10/10/2011 - 10/16/2011	1,538	1,520	50.3%	49.7%	3,058
56	10/3/2011 - 10/9/2011	1,804	2,353	43.4%	56.6%	4,157
58	9/26/2011 - 10/2/2011	2,225	3,785	37.0%	63.0%	6,010
58	9/19/2011 - 9/25/2011	1,915	3,697	34.1%	65.9%	5,612
59	9/12/2011 - 9/18/2011	2,182	4,180	34.3%	65.7%	6,362
59	9/5/2011 - 9/11/2011	1,789	3,889	31.5%	68.5%	5,678
60	8/29/2011 - 9/4/2011	3,499	6,093	36.5%	63.5%	9,592
60	8/22/2011 - 8/28/2011	4,921	8,737	36.0%	64.0%	13,658
60	8/15/2011 - 8/21/2011	4,270	12,732	25.1%	74.9%	17,002
60	8/8/2011 - 8/14/2011	5,124	12,976	28.3%	71.7%	18,100
60	7/25/2011 - 8/7/2011	8,314	18,876	30.6%	69.4%	27,190
60	7/11/2011 - 7/24/2011	5,452	11,013	33.1%	66.9%	16,465
60	6/27/2011 - 7/10/2011	3,850	6,814	36.1%	63.9%	10,664
60	6/13/2011 - 6/26/2011	4,790	8,438	36.2%	63.8%	13,228
60	5/30/2011 - 6/12/2011	4,880	8,939	35.3%	64.7%	13,819
60	5/16/2011 - 5/29/2011	5,321	10,273	34.1%	65.9%	15,594
61	5/2/2011 - 5/15/2011	4,119	7,238	36.3%	63.7%	11,357
61	4/18/2011 - 5/1/2011	3,855	5,509	41.2%	58.8%	9,364
TOTALS		69,848	137,062			206,910

The results of this tracking showed that 34% of the total Tdap vaccines provided statewide were not VFC eligible and it is likely that a majority of these doses could have been reimbursed by a third party payor. By LHD, the total percentage of 317 administered doses ranged from 11.4% (Tehama County) to 89.7% (Pasadena City).

Local Analysis

A variety of data has been collected during the planning process. First at the local level, an analysis was done of VFC Eligibility status for the two previous fiscal years. Results showed that in the 2008/09 fiscal year, 77% of the clients receiving vaccinations were documented as VFC eligible. In 2009/10 fiscal year, the percentage of VFC-eligible clients decreased to 57%. Based on these two years of data, it was estimated that between 23% to 43% of clients served received 317 funded vaccines and paid only a small administration fee since the department did not collect insurance information or bill during these fiscal years. Analysis of this same data was done to determine the potential revenue (utilizing CDC vaccine pricing) that would have been received if the department had billed private insurance for these non-VFC eligible individuals. The results of this analysis showed potential revenue of \$210,640 for the cost of the vaccine for fiscal year 2008/09 and \$228,931 for fiscal year 2009/10. The limitations of this data are that it is not known what percentage of the non-VFC eligible clients actually had insurance coverage.

Profile of Payors and Insurance Plans

State Level

In the state of California, nearly 19% of the civilian, non-institutionalized population has no health insurance coverage, but the likelihood of coverage changes depending on one's age. Nearly all adults 65 years and older have health insurance coverage (98.3%). This is largely due to Medicare, as 96.5% of this population is covered by public insurance programs. Children under the age of 18 years also have a high rate of health insurance coverage (91.0%), but only 60.9% of this age group is covered by public insurance programs such as Medi-Cal. The rest are insured by private insurance or a combination of both. It is adults in general who most often lack health insurance coverage as many of them do not qualify for public health insurance programs. Only 74.6% of adults aged 18 to 64 years report health insurance coverage and only 18.1% of those with coverage are covered by public insurance programs.

Health insurance coverage also varies by race/ethnicity. Only 70.8% of California residents who identify as Hispanic had health insurance coverage in 2010. In contrast, 85.2% of residents who identify as Asian reported having health insurance coverage. Health insurance coverage was reported by 83.2% of White residents, 84.3% of Black residents, 77.6% of American Indian/Alaskan Native residents, 79.9% of Native Hawaiian/Pacific Islander residents, 67.2% of residents who identify as "Other", and 86.1% of residents who identify as two or more races.

Of the civilian non-institutionalized population aged 18 years and older, 21.8% have no health insurance coverage. Of those in the labor force who are unemployed, nearly half (46.6%) are uninsured. Income also factors into the likelihood of having health insurance coverage. For households making less than \$50,000 in 2010, 26.4% were uninsured. In comparison, only 8.4% of California households with an income of \$100,000 or above lacked health insurance coverage. (Source for above data: American Community Survey 2010 1-year Estimates)

There are 214 companies listed with the California Commission of Insurance who provide health insurance in California. The top ten companies by market share are Anthem Blue Cross Life & Health Insurance Company, United Healthcare Insurance Company, Aetna Life Insurance Company, Blue Shield of California Life & Health Insurance Company, Health Net

Life Insurance Company, Metropolitan Life Insurance Company, Connecticut General Life Insurance Company, Guardian Life Insurance Company of America, American Family Life Assurance Company of Columbus, and Unum Life Insurance Company of America.

Health insurance is regulated by the California Department of Insurance; however “health maintenance organizations” (HMOs) are regulated by the California Department of Managed Health Care (DMHC). DMHC lists 124 licensed plans, which include chiropractic, dental, vision, pharmacy, psychological, QIF, and full services plans. In Kern County, there are twelve full service HMO plans including Aetna Health of California, Blue Cross of California, California Physicians’ Service, Cigna HealthCare of California, GEM Care Health Plan, Health Net of California, Heritage Provider Network, Kaiser Foundation Health Plan, Kern Health Systems, Scan Health Plan, UHC of California, and Universal Care. In general, HMOs require that patients utilize pre-approved providers and do not contract with outside sources, such as the local health department.

Local Level

A survey was conducted in the main KCPHSD’s clinic to identify the most common private insurance carriers with which clients were enrolled. This survey identified the most common insurance carriers were Anthem Blue Cross, Self-Insured Schools of California (SISC), Blue Shield, United Health Care, Aetna, Gem Care, Humana, Cigna, and Managed Care Systems (MCS).

Credentialing

Credentialing is an important part of the contracting process with medical insurance companies. It is a fundamental part of the process for medical billing and is done before claims can be filed with private insurance companies, Medicare or Medi-Cal. The organization and its providers must be credentialed as participating providers in order for insurance companies to pay for medical claims. The credentialing process should include all physicians, nurse practitioners, physicians assistants, health clinic/group, and laboratory.



Credentialing is used to evaluate and qualify applicants seeking to provide medical services to the insurance company's policy holders/members. Credentialing documents the identity, education, professional credentials, work history of providers, malpractice suits, and discloses license restrictions or sanctions. Credentialing processes vary from one insurance company to another. Some insurance companies credential only the group as a whole, while others credential the group as well as individual providers.

Many insurance companies prefer to utilize universal credentialing. The Council for Affordable Quality Healthcare (CAQH) is a centralized database that collects information from providers, groups, and laboratories for credentialing purposes. This system allows most common third party payors access to verify credentialing information of individual providers, healthcare groups, and laboratories. The CAQH information system is accessible by authorized providers, practice managers or participating organizations. Each practitioner submits a application and update it on a quarterly basis to meet the needs of all of the health plans participating in the CAQH database. Health plans obtain the credentialing information directly from the database, eliminating the need for health plans to complete individual credentialing.

To become a CAQH provider, an ID number and password is assigned by an insurance organization affiliated with the clinic. There are over 500 organizations affiliated with CAQH, including United Healthcare, Blue cross Blue Shield, Aetna, Cigna and Humana. If your clinic is not currently affiliated with any of these carriers, contact CAQH to obtain a list of carriers in your area. Once you contact your affiliated carrier, you need to request to be added to the carrier's roster as a provider for CAQH. An ID number will be generated and provided to you. An ID number should also be requested for each M.D., D.O., N.P., and P.A. in your clinic. After you have received the User ID and Password, log in to CAQH and begin the credentialing process. There is a detailed Quick Reference Guide available at <https://upd.caqh.org/oas/> that can assist with completing the process .



While some insurance companies utilize the universal credential system, others prefer to use their own credential system. Insurance carriers will ask that the clinic/group, laboratory and each provider are credentialed through the insurance company's process.

The following items are needed for completion of the credentialing process.

1. Tax I.D. Number

Each public health agency should have a Federal Tax I.D. number. In some cases the Tax I.D. is shared under the county's Federal Tax I.D. number.

2. National Provider Identifier – NPI

National Provider Identifiers (NPI) is issued to all medical professionals by the federal government. NPI numbers were issued to replace the former Unique Physician Identification Number (UPIN) issued by Medicare to identify providers. Each licensed provider, clinic, and laboratory must have an NPI number in order to bill for services rendered. The numbers are obtained from the National Plan Enumeration System (<https://nppes.cms.hhs.gov/>), a federal government organization. An online or paper application for an NPI number is available. Group, clinic or lab applicants should apply as an organization and providers (M.D., D.O., N.P., and P.A.) should apply as an individual applicant. NPI numbers also must be obtained for other licensed/professional personnel (i.e., R.N., L.V.N., M.S.W., Health Educators) in order to bill for services. NPI numbers are a part of the billing process and need to be updated regularly to ensure proper billing. See Appendix A for instructions on obtaining a NPI number.

3. Certifications/Curriculum Vitae

It is vital to ensure that all provider certifications are current. All certifications can be verified online. Before credentialing with an insurance carrier, review and verify all medical staff certifications. A curriculum vitae (resume) is a requirement of many insurance carriers. Usually medical professionals will already have curriculum vitae prepared. Certifying each provider should be completed before contracting with a carrier.

The following websites are a useful tool for verifying certifications:

- Medical License – Medical Board of California
<http://www2.mbc.ca.gov/LicenseLookupSystem/PhysicianSurgeon/Search.aspx>

To search for a license on this site, enter the requested information and click the search button.

The screenshot shows the 'MEDICAL BOARD OF CALIFORNIA LICENSE LOOKUP SYSTEM' search interface. It features a 'Physician/Surgeon Search:' section with a note: 'Note: If your physician is an osteopathic doctor (D.O.), click [here](#).' Below this, there are search options: 'Search By Name:' with fields for 'Last Name', 'First Name Filter (optional)', 'City Filter (optional):' (set to 'DISABLED'), and 'County Filter (optional):' (set to 'DISABLED'). There is also a 'Search' button. Below the name search options, it says '- or -' and 'Search By Number:'.

- Drug Enforcement Administration (DEA)

<http://www.deadiversion.usdoj.gov/>

To search for a certification on this site, Click on the registration validation link.

The screenshot shows the homepage of the 'U.S. Department of Justice Drug Enforcement Administration Office of Diversion Control'. The main heading is 'Office of Diversion Control'. Below the heading, there is a navigation menu with links: 'Home', 'Registration', 'Reporting', 'Info & Legal Resources', and 'Inside Diversion Control'. The central content area features the text 'Report Illicit Pharmaceutical Activities' and two phone numbers: '1-877-RX-ABUSE' and '1-877-792-2873'. To the right, there is a 'Quick Links' section with links: 'Renew Applications Online', 'New Application Online', 'Duplicate Certificate Request', 'Registration Validation', 'Registration Change Request', 'Order Forms', and 'CSOS'. The bottom left corner has the slogan 'Got Drugs?'.

- American Board of Preventative Medicine (ABPM)

<https://www.theabpm.org/>

To search for a certification, click on the Verifications and Searches, and enter the information required for the search.

The screenshot shows the homepage of the 'American Board of Preventative Medicine (ABPM)'. The top navigation bar includes links: 'Home', 'About us', 'Online Services', 'Getting Certified', 'Staying Certified', 'Verifications and Searches', and 'Resources and Publications'. The main heading is 'Welcome to the American Board of Preventative Medicine'. Below the heading, there is a paragraph of text: 'The American Board of Preventative Medicine (ABPM) provides this web site as a service to our clients - our Diplomates, applicants, residents, residency program directors, and the general public. The look and enhanced functionality of our web site is designed to meet the needs of our clients in a more efficient and comprehensive way. Virtually all the interactions between our clients and the Board staff can be conducted through the various features of the web site. However, we are available for telephone calls between 9:00 AM and 4:30 PM, Monday through Friday at (312) 939-ABPM [2276] if we can be of further assistance.' The ABPM logo is visible on the left side.

- Board of Registered Nursing--Validating a Registered Nurse License

<http://www.rn.ca.gov/index.shtml>

To search for a license, click on the Permanent License verification link and enter the required information to conduct your search.



- Vocational Nurse License Verification

<http://www.bvnpt.ca.gov/>

To search for a license, click on the Online License Verification, then Vocational Nurses License Verification and enter the requested information to complete your search.

4. Agency Certifications and Licensure

The credentialing applications will also require various certifications and licensures specific to the agency. Some of items that are required include (but are not limited to) the following:

- Agency Tax ID Number;
- Group National Provider Identification (NPI);
- Laboratory National Provider Identification (NPI);
- Clinic Permit – Board of Pharmacy http://www.pharmacy.ca.gov/online/verify_lic.shtml;
- Clinical Laboratory Improvement Amendments (CLIA) Certificate of Compliance. <https://www.cms.gov/CLIA/> Click on Laboratory Demographics lookup. Enter all required information to search for certificate;
- Medicare Account Number;
- Hospital Transfer Agreement: This is usually an agreement with the county hospital to allow for transfer of patients needing more urgent medical care. Having this agreement can take the place of the physician having admitting privileges to a hospital which is usually required when obtaining contracts with health insurance carriers;
- W-9;
- EIN/SS-4 IRS form;
- Malpractice Face Sheet;
- Medical Staff Roster and Curriculum Vitae for each staff member;
- All Certifications for each medical staff/provider;
- List of Services offered in your facility.

TRANSFER AGREEMENT BETWEEN		
Kern Medical Center 1700 Mt. Vernon Ave Bakersfield, California 93306	And	Kern County Public Health Services Department Bakersfield Facility 1800 Mt. Vernon Ave Bakersfield, California 93306
To facilitate continuity of care and the timely transfer of patients and records between the Kern Medical Center and the Institution, the parties named above mutually agree as follows:		
<ol style="list-style-type: none">1. When a patient's need for transfer from one of the above institutions to the other has been determined and substantiated by the patient's physician, the institution to which transfer is to be made agrees to admit the patient as promptly as possible, provided admission requirements in accordance with federal and state laws and regulations are met.2. The transferring institution will send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the completed transfer and referral forms mutually agreed upon to provide the medical and administrative information necessary to determine the appropriateness of the placement and to enable continuing care to the patient. The transfer and referral forms will include such information as current medical findings, diagnoses, a brief summary of the course of treatment followed in the transferring institution, nursing and dietary information, ambulation status, and pertinent administrative and social information, as appropriate.3. The Kern Medical Center shall make available its diagnostic and therapeutic services, on an outpatient basis as ordered by the attending physician subject to federal and state laws and regulations.4. The institution responsible for the patient shall be accountable for the recognition of need for social services and for prompt reporting of such needs to the local welfare department or other appropriate sources.5. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.6. The transferring institution will be responsible for effecting the transfer of the patient, including arranging for appropriate and safe transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulations.7. Charges for services performed by either facility shall be collected by the institution rendering such services, directly from the patient, third-party payor, or other sources normally billed by the institution. Neither facility shall have any liability to the other for such charges.8. The governing body of each facility shall have exclusive control of policies, management, assets, and affairs of its respective institutions. Neither institution shall assume any liability by virtue of the agreement for any debts or other obligations incurred by the other party to this agreement.		

Fees and Fee Structure

Kern County has had an ordinance in place to collect fees for certain services since 1986. Prior to this time all service provided by public health were done free of charge to the client receiving services. The creation of the first fee schedule back in 1986 set many public health nurses in a panic believing that individuals would not be able to receive services. Charging fees for services seemed to go against the goal of assuring these services were available to clients who may have limited resources. These employees were not accustomed to asking for money and many times it was easier to “waive” the fee instead of asking for payment from clients they believed “wouldn’t be able to pay”. Now twenty-five years later, these fees have become necessary in order to continue providing many services. These fees also are mandatory to be in place in order to be able to collect reimbursement from Medi-Cal, Medicare, and private insurances. A service that is billed to a third party payor cannot be provided for free (without a reason for waiving the fee) to another client. Therefore, one of the first steps to successfully setting up a billing system is to establish a fee structure.

Establishing Fees

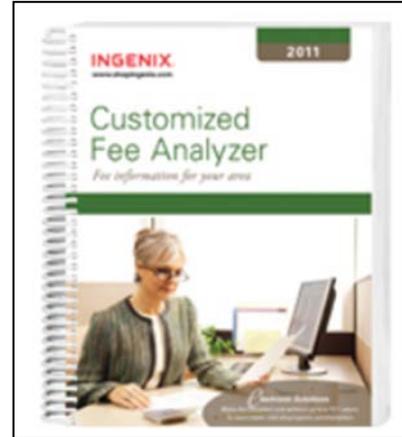
1. Evaluate costs of doing service

It is important to first evaluate the cost to the health department for delivering the services. This analysis must take into account other funding sources that may cover some of these costs (i.e., allotted tax dollars, grants, volunteers, etc.). When providing services to the public, fees should be set to cover the costs, not to make a profit. Public health services should not be in competition with available private services, but at the same time fees cannot be set so high that clients will not utilize the services. Some questions that need to be asked when doing this evaluation include: “What is the lowest amount that can be charged to pay for the service?” or “At what price does the cost become a barrier for the client?” or “What does it actually cost the department to provide this service to the community?”

2. Determine “usual and customary” fees for a service

“Usual and customary” fees are a method for standardizing the cost of service. These fees often vary across the country by region based on the prevailing cost of doing service

in that area of the country. There are different resources available to determine the usual and customary fees. For the project Kern County utilized a product called *Customized Fee Analyzer: Fee Information for Your Area and Specialty* published by Ingenix.



3. Determine Medi-Cal and Medicare rates

Next a comparison should be made between the costs for doing services, the usual and customary fees, and what the typical Medi-Cal and Medicare rates are for the services. Private insurance carriers typically reimburse higher amounts than Medi-Cal rates so it is important to take this into consideration when setting the fee in order to maximize the revenue that can be billed. At the same time, this amount cannot be higher than the cost of the service and cannot create a barrier to clients receiving services.

4. Set the fee

Once the above steps have been completed, then the fee can be set. The fee schedule that is developed can be very

comprehensive, listing every service and corresponding fee (like Kern County's schedule) or it can be very simplified. For example, Kern County set immunization fees at the cost of the vaccine plus a \$13 administration fee. As another example, Merced County has a very simplified fee schedule.

IMMUNIZATION MATERIALS
 (Replaces Schedules A and B effective June 22, 2007)

Schedule
A

*(Family Maximum (children only) - \$40.00 per visit)

Vaccine	Fees		Total
	Vaccine	Administration	
* Comvax (HIB/HepB)	\$30.00	\$13.00	\$43.00*
* Diphth. & Tet. Toxoid with acellular Pertussis (DTaP)	\$14.00	\$13.00	\$27.00*
* Diphth. & Tet. Toxoid Pediatric Type (DT-Ped)	\$29.00	\$13.00	\$42.00*
* Haemophilus Influenza Type b (HIB)	\$12.00	\$13.00	\$25.00*
* Hepatitis A (Hep 'A')	\$13.00	\$13.00	\$26.00*
Hepatitis A Vaccine Adult formulation	\$23.00	\$13.00	\$36.00
* Hepatitis B (Hep 'B')	\$10.00	\$13.00	\$23.00*
Hepatitis B Immune Globulin (per ml) ¹ (No charge for employees)	\$83.00	\$13.00	\$96.00
Hepatitis B Vaccine Adolescent Age 19 only	\$13.00	\$13.00	\$26.00
Hepatitis B Vaccine Adult formulation	\$30.00	\$13.00	\$43.00
Herpes Zoster Vaccine (Zostavax, Shingles)	\$173.00	\$13.00	\$186.00
Human Papillomavirus (Gardasil, Cervarix)	\$146.00	\$13.00	\$159.00
Immune Serum Globulin (ISG)	\$38.00	\$13.00	\$51.00
* Influenza (Intranasal [Flumist])	\$16.00	\$13.00	\$29.00*
* Influenza (Standard, with Preservative)	\$12.00	\$13.00	\$25.00*
*Influenza (Preservative-Free)	\$12.00	\$13.00	\$25.00

Their code states:

All clinical fees will be set at the published Medicare Fee Schedule. For those services where no Medicare rate is established, fees will be at the greater of Family PACT or Medi-Cal rates. In those cases where there are no published rates in any of these programs, fee will be established at costs plus a fifteen (15) percent administrative fee.

Setting up a Sliding Scale Fee Schedule

Once the fees have been established, it is important to also set up a sliding scale fee schedule. This will allow fees for mandated services to be reduced or waived for those clients who are unable to pay. With a sliding scale fee schedule in place, services that are waived or at reduced fee for certain clients, can be billed at the set fees for other clients.

1. Determine which services need to have a sliding scale fee schedule

The services which have a sliding scale attached will be very specific to the needs of each health department. In Kern County, a sliding scale fee structure was applied to the clinician exam for family planning, well child health, and sexually transmitted disease exams. There is also a sliding scale for nursing case management services fees.

2. Determine methodology for establishing the sliding scale

Kern County set up their sliding scale by discounting fees at 30%, 50%, 75%, or 100% of the usual and customary charges established in the fee schedule. The reduced scale amounts were set utilizing U.S. Federal Government Poverty Guidelines and it is based on monthly income and family size. For those paying cash for immunization services, Kern County set the cost at a \$13 administration fee, with a maximum of \$40 per family.

SCHEDULE E COMMUNICABLE DISEASE CONTROL AND STD					Schedule E			
Determine family size then choose the income amount that corresponds to the number of people living in the household. The letter to the left of that box determines the fee for a routine or extended exam.								
Clinic Services	Usual Charge*	Proposed Fees						
		A = Min	B = 30%	C = 50%	D = 100%			
99201 New Patient/Initial/10 Minutes	\$79.00	\$13.00	\$24.00	\$39.00	\$79.00			
99202 New Patient/Initial/20 Minutes	\$98.00	\$13.00	\$29.00	\$49.00	\$98.00			
99203 New Patient/Initial/30 Minutes	\$128.00	\$13.00	\$38.00	\$64.00	\$128.00			
99204 New Patient/Initial/45 Minutes	\$183.00	\$13.00	\$55.00	\$91.00	\$183.00			
99211 Established Patient/5 Minutes	\$45.00	\$13.00	\$14.00	\$22.00	\$45.00			
99212 Established Patient/10 Minutes	\$64.00	\$13.00	\$19.00	\$32.00	\$64.00			
99213 Established Patient/15 Minutes	\$82.00	\$13.00	\$25.00	\$41.00	\$82.00			
99214 Established Patient/Comprehensive/ 25 Minutes	\$119.00	\$13.00	\$36.00	\$60.00	\$119.00			
* Usual Charge is based on actual costs and 3 rd party reimbursable rates allowed.								
Poverty Guidelines 2010								
Family Members Income Monthly Max for Sliding Fee Scale								
Family Size -->	1	2	3	4	5	6	7	8
A	\$0-\$1,083.00	\$0-\$1,457.00	\$0-\$1,831.00	\$0-\$2,205.00	\$0-\$2,579.00	\$0-\$2,953.00	\$0-\$3,327.00	\$0-\$3,701.00
B	\$1,353.75	\$1,821.25	\$2,288.75	\$2,756.25	\$3,223.75	\$3,691.25	\$4,158.75	\$4,626.25
C	\$1,669.63	\$2,246.21	\$2,822.79	\$3,399.38	\$3,975.96	\$4,552.54	\$5,129.13	\$5,705.71
D	\$2,256.25	\$3,035.42	\$3,814.58	\$4,593.75	\$5,372.92	\$6,152.08	\$6,931.25	\$7,710.42

Obtain Approval

1. Prepare the official schedule and needed ordinance codes

This step may vary from county to county depending on the legal requirement for that county. In Kern County, all fees must be approved by the Board of Supervisors and the fee must be set into the County ordinance codes. Any revisions to existing fees schedules

must also be revised in the ordinance code. Much of this preparation will be completed with the assistance of the County's legal counsel.

2. Provide notice to the public

Anytime fees are established, the public must be notified. Depending on the extent of the fees that are being established, this can be completed in a variety of ways. If the fees are completely new for the county, public workshops may need to be scheduled to provide an opportunity for the public to come and hear the changes and make comment. If changes are being made to an existing fee schedule, sometimes these changes can be made by placing a notification into the local newspaper. Again, this step may vary depending on the county, so it is best to consult with the County's legal counsel on the steps needed. For Kern County, the changes we made during this planning project only required a notification in the local newspaper.

3. Approve the fee schedule

Once the documents are complete and the public hearing or notification has taken place, then the fee schedule can be approved by the Governing Board. This process took Kern County about 6 months to complete. The major challenge incurred was the political climate which was not in favor of fee hikes for the public. We had to make it clear that this fee schedule was prepared in order to collect revenue from third party insurance payors and the sliding scale fee structure was being put in place to accommodate those clients that were unable to pay. To move forward with approval, the director of the department and the director of this project visited each board member individually prior to the board meeting. The Innovative Billing Project was discussed and the reasons for revising the fee schedule. This technique was very beneficial and reduced the questions that would have come up in public session.

Identification of Patient Information Needed for Billing

Collecting appropriate information from each patient is critical in implementing a billing infrastructure. There are several steps that need to be incorporated into the patient screening process. The role of the front office staff is critically important in collecting this information. A few minutes spent up-front with the patient or patient's responsible party will ensure accurate patient demographic information is captured.



The first step to accurately capturing needed information is the creation of a comprehensive patient demographic form. This is one of the key components for obtaining accurate information for billing. Information needed may vary depending on the age of the client and the type of insurance they have.

The core set of information needed is as follows:

Minor with Private Insurance	Minor with Medi-Cal
Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card
Date of Birth	Date of Birth
Address, city, state, zip code	Address, city, state, zip code
Phone number	Phone number
Sex	Sex
Guarantor's contact information and mailing address	Guarantor's contact information and mailing address
Policy holder's name and date of birth	Legal guardian/custody information and type of identification (i.e., Driver's license)
Patient's relationship to policy holder	Consent for treatment
Type of plan (i.e., PPO, POS, HMO)	Patient's Medi-Cal card
Identification number	Legal Guardian's financial disclosure and assignment of benefits
Payor telephone number for benefit verification	
Legal guardian/custody information and type of identification (i.e., Driver's license, state identification)	
Consent for treatment	
Patient's insurance card(s) (copy of front/back)	
Legal Guardian's financial disclosure and assignment of benefits	

Adult with Private Insurance	Adult with Medi-Cal	Adult with Medicare
Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card (legal name)
Date of Birth	Date of Birth	Date of Birth
Address, city, state, zip code	Address, city, state, zip code	Address, city, state, zip code
Phone number	Phone number	Phone number
Sex	Sex	Sex
Guarantor's contact information and mailing address	Guarantor's contact information and mailing address	Guarantor's contact information and mailing address
Policy holder's name and date of birth	Consent for treatment	Consent for treatment
Patient's relationship to policy holder	Patient's Medi-Cal card	Patient's Medicare card
Type of plan (i.e., PPO, POS, HMO)	Patient's financial disclosure and assignment of benefits	Patient's financial disclosure and assignment of benefits
Identification number		Patient's supplemental insurance information
Payor telephone number for benefit verification		Patient's Part D Insurance card
Consent for treatment		Identification (i.e., driver's license, state identification)
Patient's insurance card(s) (copy of front/back)		
Patient's financial disclosure and assignment of benefits		

As part of the registration process, it is recommended to have the following registration forms in place:

Minor	Adult
Patient registration form with the core set of information listed above	Patient registration form with the core set of information listed above
Parent/legal guardian consent for treatment	Consent for treatment
Financial Policy	Financial Policy
Release of personal health information authorization	Release of personal health information authorization
Notice of Privacy Practices	Notice of Privacy Practices

Insurance Verification

The next step to collecting information needed for billing is to verify insurance eligibility and benefits. This process can potentially be time consuming. When a third-party payor keeps



your staff on hold for inordinate amounts of time, you may start to wonder whether the registration team should take the time to verify. Unfortunately, if no verification is performed, there could be a significant cost to the LHD for denied claims and loss of copayments/coinsurance and deductibles.

There are several options to perform this task.

- Contacting the provider customer service number located on the insurance card:**
 A health insurance card contains important information and it is recommended for LHDs to retain copies of them in patient files. It is important to understand that possession of an insurance card does not necessarily imply that the patients is eligible to receive benefits. It is essential to verify a patient's eligibility and benefits prior to being seen by a clinic provider. Developing a streamlined process can save you time and cost. A useful tool to utilize in the telephonic verification of eligibility and benefits for private insurance carriers is an Insurance Verification Form (see below).

Insurance Verification Form

I'm calling from Kern County Department of Public Health to verify eligibility. We are an out-of-network-/In-network Provider. Our Tax ID is 956000925. Our NPI # is 1023167541. (either or) Do you cover preventive (or) medical services? Is there a deductible? What is the deductible? Has the deductible been met? Can I please have your name? NO COVERAGE <input type="checkbox"/>	Name of Insurance Contact:
	Preventive or Medical Service:
	Deductible: \$
	Deductible Met? YES <input type="checkbox"/> NO <input type="checkbox"/>
	Date of Call:
	Time of Call:
	Your Name:

This will help the registration staff ask the necessary questions and have the agency's NPI and Tax ID available to provide to the insurance company during the verification process. It is also important to identify whether the agency qualifies for in-network benefits (contracted) or out-of-network (no contract) benefits. Additionally, the name of the insurance representative and tracking number, if applicable, should be documented. This information is necessary in the event the claim is processed incorrectly. With this verification information document, billing staff can process an appeal to the insurance carrier if necessary. This verification process has been proven to be successful in Kern County.

- **Utilize private insurance carrier's verification website:**

The best way to do this is to go to the insurance carrier website and sign up for online access. There is no cost for this service. If you attempt to get a log-in for a particular insurance carrier website and you receive notification that you need to contact your Administrator, someone may have already signed up with the same tax identification number. Kern County encountered this because the health department shares a tax identification number with the county hospital and the mental health department. If this occurs, contact the other county departments for login access.

- **Utilize a clearinghouse:**

A clearinghouse company can also be utilized for verification of benefits. You must be enrolled with the company and there is usually a fee for this service.
(More about clearinghouses can be found in the Clearinghouse section)

Coding

Medical coding is the transformation of narrative descriptions of diseases, injuries, and healthcare procedures into numeric or alphanumeric designations (code numbers). The code



numbers are detailed in order to accurately describe the diagnosis and the procedures performed. Because medicine is not always an exact science, codes were developed to identify all reasons for seeking healthcare services. In practical terms, coding is taking the written documentation of the clinic provider and communicating that documentation into the most

appropriate, accurate alphanumeric coding that reflects what the clinic provider has done during the clinic visit.

There are many purposes for accurately coding data from the medical record. Listed below are a few examples:

- Claims reimbursement
- Evaluation of healthcare processes and outcomes
- Case management and planning

There are five coding nomenclatures that are utilized in the healthcare industry:

1. **Current Procedural Terminology (CPT):** These codes are numbers assigned to every service that a healthcare provider performs. The CPT Editorial Panel is responsible for maintaining the CPT code set. The panel is authorized by the American Medical Association (AMA) Board of Trustees to revise, update or modify codes, descriptors, rules and guidelines. The Panel is comprised of seventeen members, including eleven physicians nominated by the National Medical Specialty Societies and approved by the AMA Board. The updates are implemented yearly on January 1st.

2. **Healthcare Common Procedural Coding System (HCPCS):** These codes are alphanumeric codes that are monitored by the Center of Medicare and Medicaid Services (CMS). There are two levels of HCPCS codes. Level I HCPCS codes are based on and identical to CPT codes. Medical suppliers other than physicians, such as ambulance services or durable medical equipment vendors, utilize level II HCPCS codes. The updates are implemented yearly on January 1st.
3. **International Classification of Diseases 9th edition, Clinical Modification (ICD-9-CM):** These codes are a diagnosis coding nomenclature that provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. In this coding structure every health condition can be assigned to a unique category and given a code. The current version used in the United States was developed by the World Health Organization (WHO) and modified for the U.S. It was adopted in this country in 1979. The National Center for Health Statistics (NCHS) and Center for Medicare and Medicaid Services (CMS) are the governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM. Official ICD-9-CM guidelines for coding and reporting have been selected and approved as a coding set under the Health Insurance Portability and Accountability Act (HIPAA) for reporting diagnosis and inpatient procedures. Diagnosis coding changes take effect each year on October 1st.
4. **CPT Modifiers:** CPT Modifiers (also referred to as Level I modifiers) are utilized to provide supplemental information or adjust the description and details concerning a procedure or service provided by a clinic provider. They play a significant role in the reimbursement process. The modifiers help ensure claims are processed successfully and appropriately. While CPT codes identify specific service, modifiers are used to signify that a service has been altered due to specified conditions. They are also added to enhance the details of the CPT code. Modifiers can be found in the CPT manual.
5. **HCPCS Modifiers:** HCPCS Modifiers are used to provide supplemental information concerning a procedure, service or item within the HCPCS scheme. They indicate the precise area on the body where a procedure took place (e.g. eyelids, hands, fingers etc.).

The other type of HCPCS modifier is referred to as a service modifier and is used when:

- Extra service(s) performed,
- Atypical events occurred during a service,
- Difficulty of performing the service increased or decreased, or
- When additional physicians performed services and/or service was performed at more than one setting

Coding Resources

1. **Ingenix:** Ingenix is one of the commercial companies providing coding and billing resources. This tool provides detailed references for all CPT, ICD-9-CM, HCPCS codes and modifiers. The information provided is very technical in nature but useful for the user in assuring accurate compliance with coding and billing rules. There are several formats of tools that can be utilized with Ingenix, accessed at <http://www.ingenix.com/>.

- EncoderPro.com: This Ingenix tool provides online access. All coding and billing

references are accessible in one easy to use tool. It is necessary to purchase the user access. The benefits of this method



is that it is paperless and can be accessed from any computer workstation that has internet access. The company offers a 30 day free trial of this software.

- Books/manuals: These books need to be purchased at least annually since codes and modifiers are updated on an annual basis.



2. **American Medical Association (AMA):** AMA provides free access to coding and billing resources. Billing and coding compliance updates are also available on this site.

The advantage to utilizing this site is it provides the user with health care and compliance updates necessary for accurate billing. AMA also provides coding reference materials



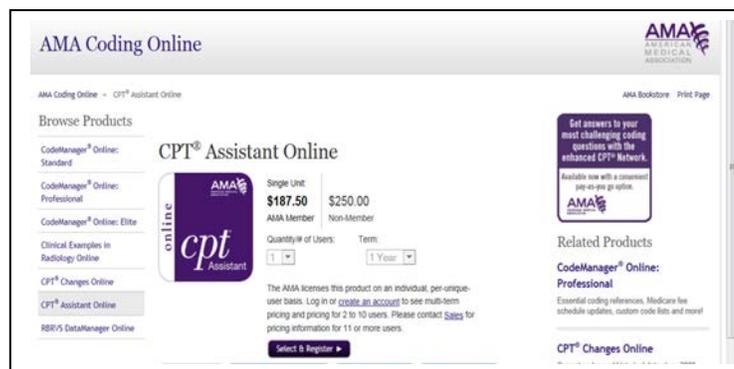
similar to Ingenix. There are several formats for these tools.

- **CodeManager Online: Professional:** All coding and billing references are accessible in this online tool. It is necessary to purchase the user access. This software allows

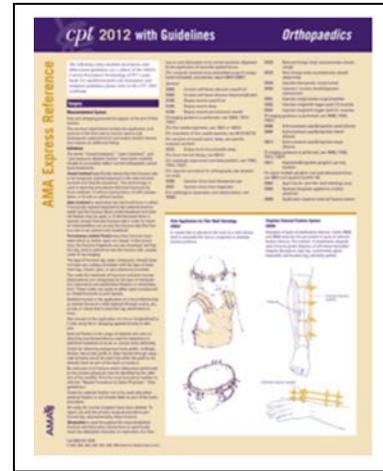


for a paperless system and can be accessed from any computer workstation that has internet access. This product offers a 14 day free trial.

- **CPT Assistant Online:** This resource provides a monthly newsletter (or online access) which provides timely CPT coding guidance each month. This resource provides the user with coding tips and interpretation to assist with



- understanding complex coding issues. It also provides timely updates when regulations have changed so the provider can be in compliance with coding rules.
- Express reference-coding cards: These are useful for quick reference for a specific specialized area. There is a fee attached to this reference.



3. **American Academy of Professional Coders (AAPC):**

AAPC provides resources for medical coding. Some of the information is provided on the web site free of charge, other information is provided for a fee. Webinars (for a fee) can be a valuable way of training multiple staff on various topics relating to coding.



4. **American Health Information Management Association (AHIMA)—AHIMA**

provides medical records professionals with educational resources and programs. The



AHIMA website provides excellent resources on coding, ICD-9, reimbursement, electronic health record management (HER), ARRA/HITECH, privacy, security, and confidentiality, health information exchange, and other beneficial topics.

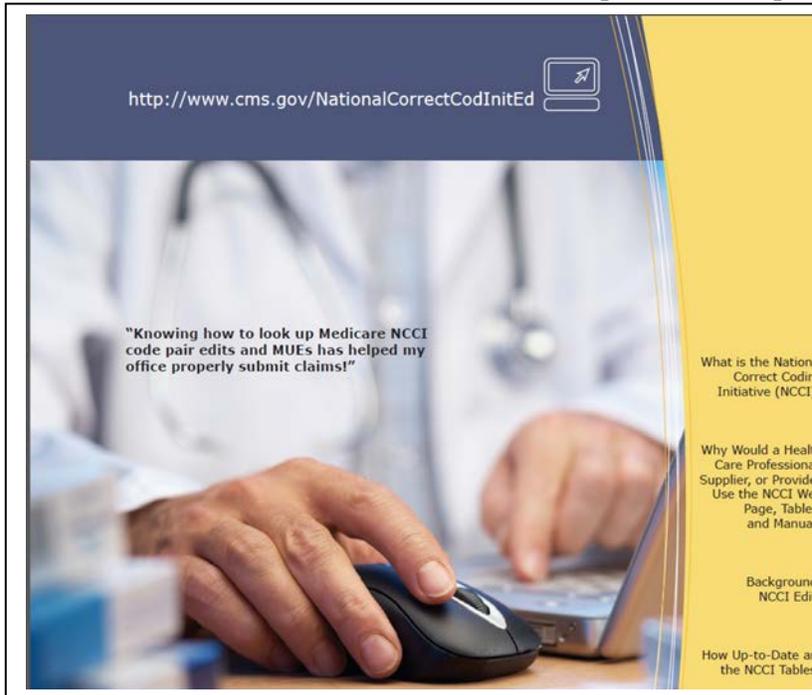
5. **Centers for Medicare & Medicaid Services (CMS):** CMS is the government agency

for Medicare and Medicaid billing. The CMS website provides information on

regulations, guidance, and standards as it relates to coding and billing for Medicare and Medicaid. Many private insurance companies, like Blue Shield, follow similar guidelines in their practice.



6. **National Correct Coding Initiative (NCCI):** NCCI is an important tool available on the CMS website. This initiative was implemented to promote correct coding



methodologies nationally and to control improper coding that leads to incorrect payment. It basically establishes the bundling of procedures that are acceptable for proper payment. For example, if a limited office visit is billed then venipuncture procedure cannot also be billed separately as it is actually part of the limited office

visit.

7. **Medi-Cal:** Medi-Cal is California's Medicaid program. The Department of Health Care Services is responsible for the Medi-Cal program in California. This site provides access to monthly bulletins which highlight any updates or changes in regulations for billing

Medi-Cal. Updates should be reviewed on a monthly basis. Up-to-date Medi-Cal manuals can be accessed on-line so the provider does not have to keep hard copy binders that may be outdated. Free webinars and trainings can be



accessed on this site saving time and cost of traveling to off-site trainings. Current



eligibility of Medi-Cal clients can also be verified on this site. With a login and password, the provider can check on several items including claim status, payments that have been released, and the current

reimbursement rate for a procedure.

Coding Certification

While it is not a requirement to have a certified coder on staff, this certification can be beneficial to the organization. An employee with certification has acquired a strong foundation of coding concepts, rules and regulations that can be applied when billing for services. This knowledge foundation will also improve compliance within the organization and reduce the possibility of inaccurate billing that could result in a pay-back to the payor. There are different types of certification available to organizations:

1. **American Academy of Professional Coders (AAPC):** AAPC is the nation's largest

medical coding training and certification association for medical coders and medical coding jobs.



This

association provides training and certification for individuals interested in coding and billing medical services. The focus of the certification received from this organization is physician practices, clinics, and outpatient services. The advantage of having staff who are certified coders is they have the broad knowledge and training necessary to understand coding concepts and can apply them accurately for successful billing. Additionally, by belonging to the local chapters of the association, they have the networking resources to be able to tackle any billing/coding issue that may occur.

2. **American Health Information Management Association (AHIMA):** AHIMA provides medical records professionals with educational resources and programs. This association provides a similar certification as AAPC except this certification also includes training and certification on health information documentation, data integrity, and quality which would be an important certification for someone in charge of medical records or implementing an electronic medical record system.



3. **Medical Association of Billers (MAB):** MAB provides training and certification to become a Certified Medical Billing Specialist (CMBS). The purpose of this training and



certification is to improve medical billing and coding knowledge and develop new skills to assist providers in maximizing reimbursement through correct coding and documentation.

Medical Documentation

The medical documentation of an office visit facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor their health care over time;
- Communication and continuity of care between physicians and other health care professionals involved in the patient's care;
- Accurate coding;
- Establishing medical necessity;
- Appropriate utilization review and quality of care evaluations.

A well-documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.



Tips for accurate medical documentation include:

1. The medical documentation should be complete and legible.
2. Each patient visit encounter should include:
 - Date,
 - Reason for the encounter,
 - History and physical exam,
 - Assessment and a plan of care.
3. Past and present diagnosis should be accessible to the treating clinician.
4. If appropriate, review of lab, x-ray data and other ancillary services should be included in the document.
5. Relevant health risk factors should be identified.

6. Patient's progress, response to treatment, change in treatment, change in diagnosis and if applicable patient non-compliance should be documented.
7. The written plan of care should include, when appropriate:
 - Treatments and medications, specifying frequency and dosage
 - Any referrals
 - Patient/family education
 - Specific instructions for follow-up

Important items to remember:

1. Clearly and legibly document the services rendered in the medical document.
2. Code and bill the CPT/ICD-9-CM codes that most accurately reflect services rendered and documented.
3. Appropriate documentation is based on medical necessity, not the volume of the document.

Documentation of time-based visits should include a description of the counseling provided and the total length of the visit. It should also specify that over half of the time was spent in counseling to make it clear that you are coding the encounter based on time rather than other key components (i.e., history, exam and medical decision making).

Vaccine documentation:

Federal requirements mandate that you document five things when you administer a vaccine (Federal law (Section 2125 of the Public Health Service Act [42 U.S.C. §300aa-26])):

1. The name of the vaccine and the manufacturer;
2. The lot number and expiration date of the vaccine;
3. The date of administration;
4. The name, address, title and signature (electronic is acceptable) of the person administering the vaccine;
5. The edition date of the Vaccine Information Statement (VIS) and date the patient or parent received it.

The VIS is a CDC-approved description of the vaccine, its benefits and adverse effects, and it includes information about the disease against which the vaccine protects. The VIS is written at a level most patients can understand, and is available in languages other than English. Current statements are available at <http://www.cdc.gov/nip/publications/vis/> and at <http://www.immunize.org/>.

It is not necessary to have the VIS signed by the patient or parent; simply provide a copy of the VIS for each vaccine administered. It is possible that a VIS may not yet be available for a newly released vaccine, and this should be documented if that is the case. The list of available statements is updated periodically, so the immunization providers should check for updates or new editions of VIS regularly.

The LHDs must document the five required components in a permanent record or log. In Kern County, the federally required information is documented in the immunization module of the EHR.

The most important thing to remember about documentation is:

If it is not documented.....It didn't happen!

Functional Job Descriptions

Front Office Registration

Importance of position:

The front office registration staff contributes to the first impression patients have to the LHD. By performing the appropriate registration procedures, this person sets the stage for a smooth and timely process for the patient experience. In the course of business, this person interacts directly with patients, visitors, management, and clinic staff.

Major Responsibilities:

- Greet patients and visitors;
- Determine the reason for the visit;
- Distribute and explain the registration forms to the patient or patient's legal guardian;
- Secure signatures on documents as needed;
- Determine the patient's method of payment and obtaining insurance information as needed;
- Input and/or update patient demographic information into the practice management system;
- If minor patient qualifies for Gateway (Child Health and Disability Prevention [CHDP] program enrollment), assist with the paperwork and enrollment process;
- Comply with all HIPAA, other regulations and requirements; and
- Handle incoming calls and other office duties as directed.



Skills, Abilities and Qualifications:

- Ability to interact with patients effectively and in a supportive manner;
- Detail oriented and ability to multi-task;
- Capable of adhering to established policies and procedures as required;
- Self-starter with the ability to work both independently and as a team-member;
- Always courteous and respectful regardless of race, creed, family and/or economic situation;
- Is flexible, able to embrace and implement change; and
- Touch typing/keyboarding with speed and accuracy.

Insurance Verifier

Importance of position:

The Insurance Verifier scope of work has become more complex and important. Health Insurance itself has become more complex. The role of this staff member is vital to the revenue process. This position is likely to also be involved with patient registration. It can vary depending on the volume of the clinic.

Major Responsibilities:

- Timely verification of medical insurance benefits with all payors;
- Document information given from the health insurance carriers on the insurance verification worksheet;
- Obtain pre-certification or authorization if needed for the immunizations and or other services;
- Ensure that the appropriate payer information is captured in the practice management software;
- Translate benefit information into the practice management system for future reference;
- Effectively communicate with the patient the benefits that they have or do not have for the services being requested; and
- Assist with front office registration.



Skills, Abilities and Qualities:

- Comprehension of translating benefit details into a written document;
- Understanding of healthcare terminology;
- Ability to multi-task and attention to detail;
- Self-starter with a positive energetic attitude;
- Excellent customer service skills; and
- Capable of interacting with patients, families, staff, management, clinic providers, insurance companies, third party payors as well as the general public in a professional manner.

Cashier/Check Out

Importance of Position:

The Cashier is responsible for the check-out process of patient clinic flow. It is a critical position to be able to successfully collect revenue for services performed. This person must be able to skillfully collect fees for services and co-pays or deductibles from patients.

Major Responsibilities:

- Determine appropriate fees based on fee schedule and procedures performed;
- Collect fees;
- Make payment arrangements as needed;
- Document payment arrangements for future reference; and
- Review encounter forms for sufficient information as quality assurance check.



Skills, Abilities and Qualities:

- Understanding of healthcare terminology;
- Working knowledge of health insurance plans and coverage types;
- Ability to translate benefit details into a written document;
- Ability to multi-task and attention to detail;
- Self-starter with a positive energetic attitude;
- Excellent customer service skills;
- Effective oral communication skills;
- Capable of adhering to established policies and procedures as required;
- Always courteous and respectful regardless of race, creed, family and/or economic situation;
- Is flexible, able to embrace and implement change;
- Touch typing/keyboarding with speed and accuracy;
- Knowledge of medical terminology a plus; and
- Bilingual language skills a plus.

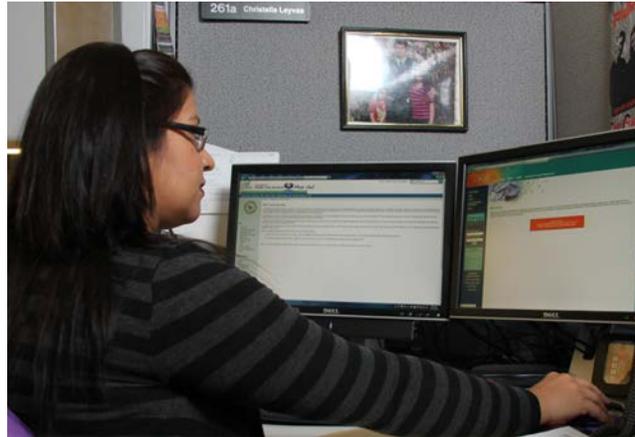
Credentialing Specialist

Importance of Position:

The Credentialing Specialist is necessary in order to keep all certifications and credentialing of providers current. Ideally one person in the organization should be assigned this role.

Major Responsibilities:

- Gather personal information from providers and complete credentialing process;
- Prepare and maintain reports of credentialing activities such as accreditation, membership or facility privileges; and
- Keep facility and laboratory accreditation up to date.



Skills, Abilities and Qualities:

- Requires strict attention to detail and good research skills;
- Self-starter with a positive energetic attitude; and
- Must be able to keep personal information confidential.

Back Office Vaccinator/Documenter (Nurse)

Importance of Position:

With the addition of a number of new vaccines over the past five years, the Nurse vaccinator plays a key role in the education and administration of vaccinations to patients. It is their responsibility to ensure that the patient is properly informed about the vaccines they are receiving and that the vaccines are administered properly. This position is responsible for giving goal directed, safe patient care based on patient need, and for supervision and coordination of care given by other team members.



Major Responsibilities:

- Review patient record(s), California Immunization Record [CIR] aka the 'yellow card', California Immunization Registry [CAIR] printout, and any other record of vaccination after the registration paperwork is completed to see what immunizations are needed;
- Discuss with the patient the vaccine(s) they will be receiving;
- Ask if the patient/guardian have read the VIS statement(s) and ascertain if they have any questions;
- Answer any questions the patient may have;
- Respond to any apprehension, additional questions the patient may have;
- Prepare vaccine(s) to be administered;
- Discuss the sites where the vaccinations will be administered;
- Vaccinate the patient;
- Give post vaccination care instructions;
- Inform patient/guardian of when to return for next visit; and
- Complete documentation of the immunizations given into the Patient Care Management System.

Skills, Abilities and Qualifications:

- Ability to assess, plan, implement, supervise and evaluate the nursing care of each patient in his/her charge;
- Responsible for the delegation and coordination of appropriate aspects of care to other medical personnel on the team;
- Maintains a safe work environment; and
- Implements and coordinates nursing measures that will facilitate the prescribed medical care.

Biller

Importance of Position:

The biller position is responsible for submitting clean claims to all private insurance, Medicare, Medi-Cal, third party payors and self-pay patients. This position is critical for successful revenue collection. Health and governmental insurance policies are often composed of complex language with numerous requirements and stipulations.

Major Responsibilities:

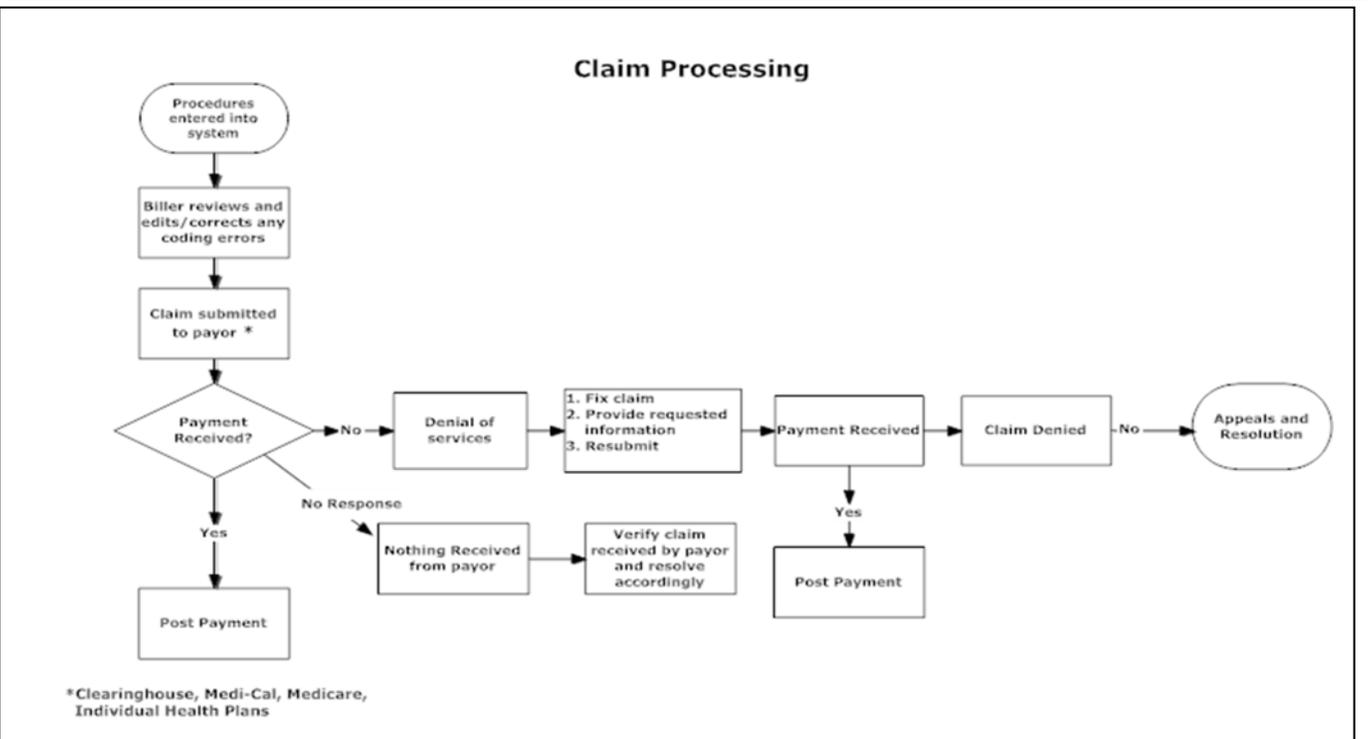
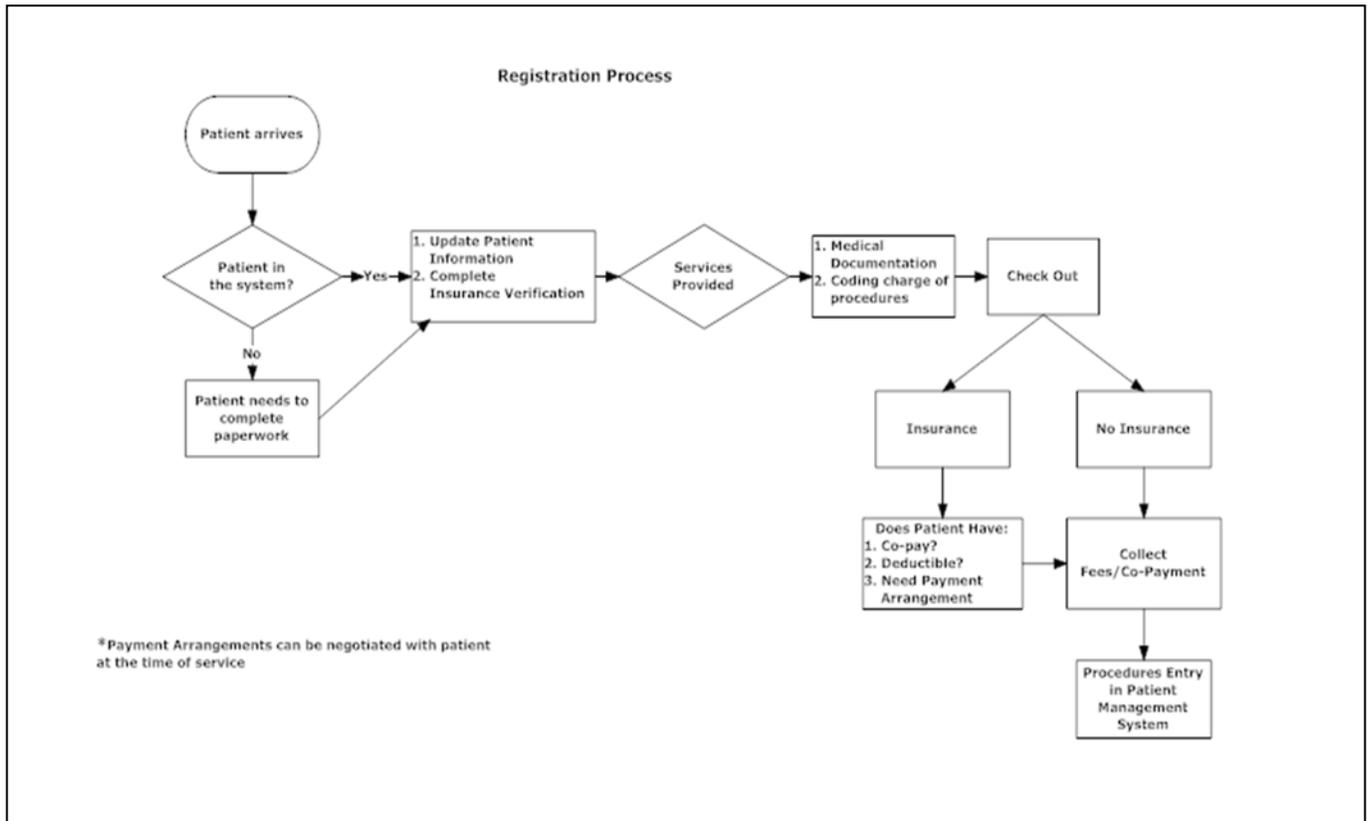
- Compile and submit both electronic and paper claims to health and governmental insurance carriers;
- Prepare and submit patient statements if appropriate;
- Post insurance and governmental insurance payments and reconcile posts to the Explanation of Benefits (EOB), Remittance Advice Details (RAD) and Explanation of Medicare Benefits (EOMB);
- Act as a resource for patients, registration staff, cashier, clinic provider, insurance companies and management;
- Identifies and resolves billing issues;
- Reviews and works the aged accounts receivable reports by payor;
- Submits appeals as necessary; and
- Promptly resolves issues related to claim denials.



Skills, Abilities and Qualities:

- Must have insurance industry knowledge, coding skills and experience;
- Superior attention to detail and problem-solving skills;
- Strong organizational and communication skills;
- Ability to establish and maintain good relationships with colleagues, patients and insurance personnel;
- Ability to maintain strictest confidentiality; adheres to all HIPAA guidelines/regulations; and
- Coding certification a plus.

Patient Clinic Flow Process



Electronic Patient Management System

Kern County hired a Health Insurance Specialist to assist with this project. The department already had in place an electronic patient management system (EMR), but did not have anyone on staff who understood the billing and accounting portions of the system. Therefore, these portions were not being utilized and the department had contracted with an outside billing company to complete billing for clinic services.

One of the first steps the Health Insurance Specialist completed was reviewing existing billing processes and learning how the billing and accounting portions of the system worked. Immediately, considerable amounts of deficiencies were identified within the billing portion of the EMR. It was necessary to work closely with Netsmart customer support to assist with getting the system set-up for billing. Examples of deficiencies found included:

- Missing provider NPIs and license numbers;
- Missing provider taxonomy codes;
- Missing Medi-Cal submitter information;
- Missing public health lab NPI;
- Incorrect fee schedule on some of the procedure codes;
- Missing 837P – professional electronic billing file.

There were numerous steps needed in order to get the system set up to bill Medi-Cal, Medicare, and private insurance carriers. These steps included:

- Updating procedure codes to the appropriate CPT codes and modifiers based on payor requirements and update associated fees;
- Entering all NPI, taxonomy codes, and license numbers for all clinic providers;
- Updating the Medi-Cal billing submitter number information;
- Purchasing and setting up a 837P (professional) electronic billing file for billing laboratory services, Medicare and private health insurance carriers;
- Performing testing with Medi-Cal and receiving approval for electronic billing out of the EMR;
- Setting up auto-posting of payments;
- Enrolling with a clearinghouse for billing all private insurance carriers;

- Setting-up all clearinghouse payor information.

When all the systems were in place for billing out of the EMR and testing was completed, the Health Insurance Specialist began to complete the billing electronically through the EMR. At this point the contract with the billing company was eliminated. Once everything was in place, it was determined that it was more cost effective for the billing to be done internally versus utilizing a billing company.

During the initial processes of setting up the system for billing, there was an identified need to establish a network with the national users of Netsmart (the EMR system). Netsmart holds an annual conference for software users. During this conference, the Health Insurance Specialist was approached by the company to assist with setting up a Insight Billing Workgroup. Kern County was asked to chair this workgroup. There are monthly "Go To Meetings" with this workgroup. Discussion has included coding instructions, system demos and billing functions, as well as guest speakers on pertinent topics. There is also a website for the Insight Billing Workgroup community and there are documents, questions, and updates that are posted for everyone to view. This provides a very impactful resource to utilize the system effectively for billing as well as address all coding and reimbursement trainings.

Contracts with Health Insurance Companies

Based on information collected on common insurance companies utilized in Kern County, the Health Insurance Specialist and staff began initiating contracts with the following companies:

Managed Care Systems (MCS)

Managed Care Systems is the managed care organization that administers health benefits for Kern County employees.

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract with MCS. (See sample intent letter in Appendix B).
2. After MCS accepted the letter of intent, the negotiating process began. MCS sent their reimbursement rates for approval. Reimbursement rates were compared against current costs to ensure the rates were not below cost.
3. The next step was to submit the contract to the county counsel for approval. Once county counsel approved the contract with MCS, the contract went to the Board of Supervisors (BOS) for final approval.
4. After BOS approval, staff was notified of the approved contract and patients were able to access clinic services utilizing this insurance.

Challenges:

- In initiating our intent to negotiate a contract, customer service representatives misunderstood that public health had a clinic that provided billable services. This was resolved by MCS communicating with the County Administrative Office (CAO) questioning our requests for a contract. After discussion with the CAO, the contract process proceeded smoothly.

Length of Time to Complete Process:

- Approximately 3 months.

Blue Shield of California

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract.
2. After Blue Shield accepted the letter of intent, the contract was sent to county counsel for review and approval.
3. County counsel did not approve the terms and conditions in the agreement due to non-standard language. The sections in question were the License Privileges and Insurance, Termination of Individual Physician in group, and Arbitration of Disputes. Blue Shield was unable to accommodate the requested changes from county counsel. Blue Shield is licensed as a health care services plan under the California Knox-Keene Health Care Service Act. The Knox-Keene Act requires health plans to include certain non-negotiable language within the agreements between the health plans and their providers. The wording in question is standard language across all insurance companies and cannot be modified.
4. The director of the department went to the BOS requesting approval of the contract with the non-standard contract language.
5. The BOS approved the contract on December 13, 2011. This contract was our test case to receive approval with non-standard contract language. (See sample Board Letter in Appendix C)
6. Once the contract was approved, then additional information was sent to Blue Shield. Blue Shield requires individual credentialing for all billable providers. A pin application is also part of the process to obtain a Blue Shield provider number (utilized for billing). These steps are currently still in process.

Challenges:

- Delays in communication between the Blue Shield contract representative and department staff.
- Delays due to the non-standard language and attempts to negotiate with Blue Shield to change language.

Length of Time to Complete Process:

- 12 months.

Anthem Blue Cross of California

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial request made to become a contracted provider.
2. Anthem responded to the department's request (via email) that due to the shared tax ID number, Anthem Blue Cross was unable to accommodate our request to become a provider.
3. The Health Insurance Specialist is currently building a relationship with Anthem Blue Cross' Healthy Families representative who is willing to try to assist the department with establishing a contract.

Challenges:

- Shared Tax ID, Anthem Blue Cross' data management system is unable to separate multiple group providers that share a Tax ID.

TriWest Healthcare Alliance

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (MD, NP) was the initial step towards securing a contract.
2. After TriWest accepted the letter of intent, the contract was sent to county counsel for review and approval.
3. County counsel did not approve the terms and conditions in the agreement due to non-standard language. The sections in question were the License Privileges and Insurance, Termination of Individual Physician in group, and Arbitration of Disputes. TriWest was unable to accommodate the requested changes from county counsel. TriWest is licensed as a health care services plan under the California Knox-Keene Health Care Service Act. The Knox-Keene Act requires health plans to include certain non-negotiable language within the agreements between the health plans and their providers. The wording in question is standard language across all insurance companies and cannot be modified.

4. Now that the BOS has approved Blue Shield with the non-standard language, the TriWest contract will be going to the BOS in January 2012.

Challenges:

- Delays in communication between the TriWest contract representative and the department staff.
- Delays due to the non-standard language and attempts to negotiate with TriWest to change language.

Humana

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract.
2. After Humana accepted the letter of intent, the contract was sent to county counsel for review and approval.
3. County counsel did not approve the terms and conditions in the agreement due to non-standard language. The sections in question were the License Privileges and Insurance, Termination of Individual Physician in group, and Arbitration of Disputes. Humana was unable to accommodate the requested changes from county counsel. Humana is licensed as a health care services plan under the California Knox-Keene Health Care Service Act. The Knox-Keene Act requires health plans to include certain non-negotiable language within the agreements between the health plans and their providers. The wording in question is standard language across all insurance companies and cannot be modified.
4. The Humana contract will be going to the BOS in January 2012.

Challenges:

- Delays in communication between the Humana contract representative and the department staff.
- Delays due to the non-standard language and attempts to negotiate with Humana to change language.
- Change in management staff at Humana.

Self-Insured Schools of California (SISC)

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract.
2. The department has not received a written response to the letter of intent although verbal interactions with the company have been positive.
3. Staff has been told SISC plans to take intent letter to their governing board for approval in January.

Challenges:

- Delays in communication between the SISC contract representative and the department staff.
- Delays due to SISC management staff on extended leave of absence, therefore unable to approve intent letter.

Aetna Insurance

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract. (See sample letter of intent in Appendix B)
2. Aetna has not yet accepted the letter of intent.
3. Aetna representative requested the department re-contact the company in January 2012.

Challenges:

- Delays in communication between the Aetna contract representative and the department staff.
- Misunderstanding that even though public health is a government agency, funding for clinic services comes from Medi-Cal, Medicare, private health insurance, and fees. Aetna did not realize that clinic service could be billed to private insurance companies by public health.

United Health Care

Steps to establishing a contract:

1. A letter of intent which included the roster of all billable providers (M.D., N.P.) was the initial step towards securing a contract.
2. United Health Care requested additional information about number of United Health Care subscribers that have received services by public health.
3. Contract negotiation/procurement is still ongoing.

Challenges:

- Delays in communication and misunderstandings between the United Health Care contract representative and the department staff.
- Delays in receiving transfer agreement with county hospital.

Clearinghouse

A clearinghouse is a company that offers a bridge between a healthcare practice/clinic and health insurance carriers. They are essentially regional hubs that enable healthcare practices to transmit electronic claims to insurance carriers. They provide a centralized place to manage all private health insurance claims.

The process is:

- The EMR creates the electronic file (the electronic claim) which is then sent (uploaded) to the clearinghouse account.
- The clearinghouse then reviews the claim checking it for errors.
- Once the claim is accepted, the clearinghouse securely transmits the electronic file to the specified payer (meeting all confidentiality and security standards required by HIPAA).

Benefits of utilizing a clearinghouse:

- Allows the biller to catch and fix errors quickly;
- Submits claims electronically which can reduce reimbursement times to under ten days;
- Eliminates the need to prepare claims and manually re-key transaction data over and over

for each
payer;

- Submits all
electronic
claims in a
batch at
once, rather
than
submitting

separately to each individual payer;

- If you subscribe to a good clearinghouse, you'll be speaking with a knowledgeable support person within just a few rings;
- Shorter payment cycles leading to more accurate revenue forecasts;
- Reduces or eliminates need for paper forms, envelopes and stamps;



- Proof of timely filing.

Items to consider when selecting a clearinghouse:

- Look for a national company versus regional;
- Review the payor lists from their website and make sure the insurance carriers you bill are on the list and that they have a large number of payors;
- Try contacting the support line to ensure there is timely service and response;
- Confirm and demo the claims acknowledgement reports;
- Review the terms of contract and steps for terminating contract if needed;
- Online access to update, track, and manage the claims that were submitted;
- Secondary insurance claim submission;
- Electronic remittance advice downloads.

How to go about acquiring the selected clearinghouse:

There are several steps that need to take place when acquiring the clearinghouse services:

1. Contact the customer service line of the selected clearinghouse and request the documents that are needed to be filled out in order to enroll for their services.
2. If appropriate, submit the documents to County Counsel for approval.
3. Once there is approval, then have the designated staff person complete the documents and submit to the clearinghouse contact person.
4. Review the payor lists in the EMR and update the list to include the payor number assigned by the clearinghouse.
5. Contact the clearinghouse technical support to schedule the training and testing.

Individual Payor Instructions

It is crucial to understand the individual payor requirements for timely reimbursement and cost effectiveness for clinic operations. There are standard instructions for billing and coding, but individual payors may have their own requirements for billing. The billing specialist should be well versed in all the payors that are billed through the clinic.

If there are payor specific instructions that are outside of the CPT coding rules, it is important to have the payor submit these requests to the LHD in writing. This will ensure that if and when there is an audit, documentation is available for review.

Billing Company

Hiring a billing company to provide billing services for the local health department has some potential advantages. They are:

- State of the art billing software;
- Access to individuals with expertise in medical coding and billing;
- Billing company staff keeping up to date with constant changes in regulations;
- Time saving and less cost in providing training for LHD staff in coding and billing rules and regulations;
- Full coverage of billing versus having delays due to vacation, sick and personal time off from LHD staff;
- Accounts receivable management is handled timely and effectively;
- Address coding or registration issues and trains appropriate staff when necessary.

Hiring a billing company to provide billing services for the LHD has some potential disadvantages. They are:

- Loss of control of the work being performed;
- Services being provided may be limited due to the lack of access to the appropriate information;
- Communication barriers between appropriate LHD staff with billing company staff;
- Possible misunderstanding of contractual agreements;
- Potential risk for coding and or billing compliance regulations;
- HIPAA privacy and security can become a greater issue when outsourcing the billing;
- A smaller clinic volume does not provide incentives for the billing company to provide billing services.

Billing Contract Negotiation Interviews

If there is a need for a billing company, it is important to ask questions that can identify potential risks and or benefits.

The below are some examples of questions to ask:

- How long has the billing company been in business?
- How many clients do they have?
- What specialties do they bill for currently?
- What resources and training does the billing staff have?
- Do they have Errors and Omissions Insurance (billing malpractice insurance)?
- What is their commitment to staff training?
- Do they have a contingency plan for disasters?
- Do they perform backups, If so, how often?
- What is the procedure for handling problem claims (missing information)?
- How often do they submit claims?
- To which insurance carriers do they submit electronically?
- What standard reports do they provide and how often?
- How often do they work the aged accounts receivable?
- How do they post rejections and denials?
- Are the rejections and denials tracked? If so, request a copy of a sample report.
- Ask for samples of the reports that they provide to their clients.
- Ask for an example of what their procedure is for transmitting information between the billing company and the customer.
- Ask to view their compliance plan.
- Ask them if they have ever been investigated for fraud and or abuse.
- Ask them for three references.

LOCAL RESULTS

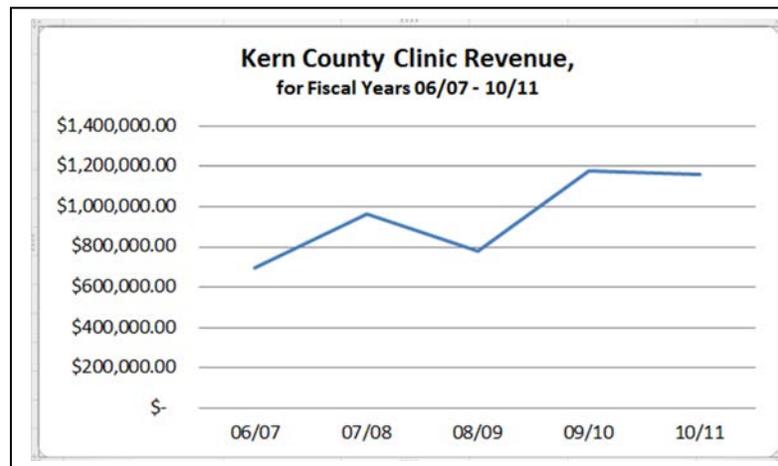
Pilot Tdap Project

Once the contract with MCS was approved, the department utilized this opportunity to provide Tdap to MCS subscribers and bill for the services. Between June 4, 2010 and November 24, 2010, 75 MCS subscribers received Tdap in the clinic. MCS was billed \$3,375 for the vaccine (\$45/vaccine) and \$1,470 for administration of the vaccine (\$20/vaccine). The department received payment from MCS in the amount of \$2,989 for the vaccine. This was 89% of the amount billed. The department received \$690 for administration of the vaccine, which was 47% of the amount billed. The success in the collection rate was due to having a contract in place. This definitely validates the importance of going after contracts with insurance companies.

Revenue

With the tremendous reductions in local, state, and federal government funds, providing clinic services to the public has become an increasing challenge. As mentioned previously, Kern County already had a nominal fee schedule in place, was billing Medi-Cal, Family Pact, and

some private insurance (without any contracts). The department was receiving a large denial rate on billing and many of these denials were not being rebilled. Bringing an insurance specialist on board, resulted in almost immediate increase in clinic revenue. Because the insurance



specialist had coding experience, within the first month of employment (hire date February 2010), she was able to correct some coding errors in the system and coding documentation for services billed to Family Pact. Revenue collected went from \$42,961 (collected between 7/09-12/09) to \$491,317 (collected between 1/10-6/10). Private insurance revenue increased from \$6,087 collected in a 6 month period prior to the start of the project (7/09-12/09) to between

\$9,568 and \$11,681 per 6 month period since 1/1/10. This increase is significant given the fact Kern currently only has one contract completed for preferred provider status. Clinic fees (cash from patients) collected increased by over \$40,000 in a 6 month period after the implementation of the new fee schedule. Prior to 1/1/11, fees collected in a 6 month period were between \$128,746 and \$134,481. Since 1/1/11, fees collected have been between \$160,930 and \$174,791 for a 6 month period.

Presentations

Nationwide, there was a lot of interest in this project. California was no exception. Over the course of the project, staff provided several presentations and trainings. Presentations done included:

- In May 2010, the Director of the Project provided a presentation about the billing project to all of the Immunization Coordinators at the statewide meeting.
- On May 16, 2011, the Insurance Specialist was asked to present two break-out sessions at Netsmart's annual conference in Orlando, Florida. The titles of the sessions were: *Bridging Billing and Front Office Registration and Contracts.*

Potential Benefits of the Billing Project

In the summer of 2010, Kern County's public health clinic was threatened closure due to decreased county revenue. The only service that was being considered to be continued was immunization services. Public hearings were held on the fate of the clinic where citizens and local providers spoke on behalf of keeping the clinic open. The decision was made to keep the clinic open. A major factor that aided the Board of Supervisors' decision to keep the clinic open was this billing project. We were able to show that with this project and with the work that would be done with correcting coding, billing private insurance, and revising the fee schedule, not only would an increase in revenue in the clinic be realized for immunization services but also for all other services (TB, STD, etc.).

With staff realizing their jobs were on the line and that their jobs could potentially be on the line in the future, the mind set for collecting monies from patients changed. Employees who were once apprehensive about asking patients to pay for services or who often chose to waive all the fees if a patient said they could not pay, are now more comfortable with discussing services

and payment options with clients. They are less likely to waive the fee, but will rather ask the patient what amount they can pay today and discuss a payment plan with the patient.

A big success of this project was realized when comparing our back to school immunization campaign for the last two school years (2010/11 and 2011/12). Kern sees a large influx of students coming to the department for immunizations during the week before and the first week of school. Prior to this project, staff would have taken insurance or Medi-Cal card information as payment for shots. Then, after the fact, staff would have determined the card information was bad and the department would have received no payment for the immunizations. During the 2010/11 back to school immunization clinics (towards the beginning of this project), our insurance specialist was in high demand assisting and training on-demand all of the registration staff with insurance card and Medi-Cal card questions and verifications. Clients were asked to pay cash if their insurance/Medi-Cal card could not be verified. During the 2011/12 back to school immunization clinics, staff was now fully trained on how to interpret insurance and Medi-Cal cards and complete verification of benefits. They were able to complete these tasks without intervention from the insurance specialist. As a result, the high volume clinics each day went much smoother and more revenue was collected.

Barriers

- **Contacting Insurance Companies:** The process of contacting insurance companies presented itself as a major barrier. When we applied for this grant, we did not know the challenges we would face. During the process we found out after contacting each insurance company that in order for them to discuss the possibility of us being a preferred provider we had to initiate a letter of intent, detailing our services and the expected outcome for their member and for us if we entered into a contract with them. Most companies were sent multiple letters with multiple telephonic follow-up over the period of the grant, most without any successful resolution. Each insurance company varied in how they do business and who in their organization would make a decision to contract or even who the contact person was. With some companies, the contact person or decision maker changed with each call.
- **Staffing:** Another barrier encountered early on was that existing staffing classifications do not always meet the skill set needed for coding and billing. Individuals on the staffing

roster lacked billing and coding experience and there were no trained coders on staff which was a hindrance to moving the project forward. From front office to back office staff, no one was comfortable discussing payment or payment options with patients and would often times waive the fee for services. Patients were informed that if they could not pay the fee it would be waived, so some patients who presented to our clinics multiple times were already conditioned to this fact. Some staff had difficulty retaining knowledge and required repetitive training.

- **Changing Fee Schedule:** Even though revenues were down for our clinics and the county as a whole, changing our existing fee schedule took some time to get this accomplished. No one wanted to see the fees increased. It took some time and individual meetings with each board member to show the benefits of changing the fee schedule. The fee schedule we had in effect was from 2007 and many of the prices, especially for county purchased vaccines, were out of date. Patients were charged the cost of purchasing the vaccine plus an administration fee for most vaccines which for over twenty years was \$3.00. However if the cost of the vaccine increased from the manufacturer/supplier, which it often does, there was no mechanism in place to increase the fee so that the patient was covering the cost of the vaccine. It took close to 8 months to complete the process for updating this fee schedule.
- **Shared Tax ID:** In the process of trying to implement this project we quickly found out that the Tax ID for our department was shared with the local county-run hospital and with the mental health department. We found out that claims submitted to payors that did reimburse for our services usually ended up being paid to the hospital instead of the health department. There was no easy way to identify which claims belonged to us. Payments for claims sent to the hospital that they could not reconcile, went into a general fund. It was not until we started this project that we realized the hospital was getting our clinic revenue. This continues to be a challenge requiring many staff hours to track claims and figure out where the payment was sent. Often batches sent by the hospital and by us are combined into one batch and paid and reported out on one Explanation of Benefits (EOBs) statement, making it difficult to determine which patients are public health clinic patients. Another difficulty in having a shared Tax ID is when trying to negotiate contractual agreements with the insurance companies, they would state that

they already had someone with this Tax ID and would not want to either do business with us or add our providers to the roster.

- **Accounts Receivable Reporting:** Being able to extract data out of our EMR to monitor success was a major challenge. The system's canned reports did not provide enough detail to be able to monitor success. The complexity of the system and proprietary software made it impossible for in-house technical staff to be able to extract data from the EMR for analysis.

IMPLEMENTATION

Six local health jurisdictions in California will be identified to participate in the implementation project. In consultation with State staff, we will evaluate the data collected from the planning process to identify the six jurisdictions that would best represent the landscape of the State to participate as implementation jurisdictions. We will make contact with the jurisdictions chosen to further identify the key players in each jurisdiction that will be involved in the project. Site visits will be made to each jurisdiction to assess the site and prepare for individual needs during the training process.

Training modules will be developed for the six jurisdictions. Training components will include but are not be limited to: fee schedule, credentialing, understanding coding, “front office” registration processes, verification of benefits, “check out” processes, contracting with insurance companies, and billing processes. The implementation team will incorporate information gleaned from the site visits, including forms specific to each jurisdiction and other local nuances, into the training modules.

Once the training modules have been developed the implementation team will set up and complete training at each site with the key players. Upon completion of the trainings, modifications to the training modules will be completed, incorporating input and lessons learned from the six local health jurisdictions.

Feedback surveys will be compiled and administered to the six jurisdictions. The team will develop and finalize on-line webinar training modules incorporating the lessons learned during the trainings and the results of the surveys. The number of modules to be developed and general content of each module will be gleaned from the first few trainings conducted. The implementation team will work with the State's IT/Graphics department to complete the on-line webinar training modules.

A “help-line” support system will be established to provide post-training, on-going consultation and support for the six health jurisdictions. The process for contacting a member of the implementation team for consultation either by phone, email, or webinar will be done along with the development of a database for collecting information on the type of help provided and the amount of time spent providing assistance. Through the duration of the project, the

implementation team will provide ongoing consultation and support as needed by the jurisdictions after training has been completed. A billing workgroup for California jurisdictions will also be established. This workgroup will involve a monthly teleconference to establish a network within the counties for ongoing support of billing services.

Efforts will be made to establish state-wide contracts with insurance carriers for immunizations services if feasible. State staff personnel hired will work with the Insurance Commissioner and identify health insurance carriers in California where a state contract for immunization services would be beneficial for all jurisdictions. The State staff and implementation team will work together to procure at least one state contract with an insurance carrier if it is determined to be feasible.

Utilizing the California Immunization Registry, we will work on the development of a centralized system to track doses of 317 vaccines that is reimbursed to local health jurisdictions by private insurance, so reimbursement can be used by the State to re-purchase additional vaccine. The implementation team will first implement a manual system of documenting identified components in the six local health jurisdictions. Utilizing data collected from manually implementing the tracking system, we will work with State IT staff to develop the tracking component in the California State Immunization Registry.

A plan for implementing ICD-10 diagnosis codes by the required date of October 2013 to be in compliance with billing regulations will be developed. Research will be completed to identify the components of the ICD-10 diagnosis codes needing to be in place. A webinar training with instructions on how to convert to the ICD-10 codes will also be developed. The training will include a checklist of tasks needing to be completed in order to be compliant by October 2013. After the webinar training, the Implementation team will provide technical assistance to jurisdictions in completing the tasks needed to become compliant.

A written evaluation of the implementation plan will be completed which will include pre and post knowledge tests to be utilized during the trainings at each jurisdiction, a post training satisfaction survey by each jurisdiction, a follow-up survey (similar to the survey completed during the planning project) to evaluate the types of billing done in California jurisdictions and compare it to the previous survey. The evaluation will also include data analysis of the information collected during the "help line" support system to determine the need for continuing

support once this grant project is complete and a post evaluation of the six jurisdictions to determine the effectiveness of their implementation of a billing system.

The success of this implementation project will be measured by completing the following deliverables:

1. Identification, site visits, and agreement from six health jurisdictions to participate in the implementation project.
2. Development of the initial training modules for the six health jurisdictions.
3. Completion of training at the six health jurisdictions.
4. Completion of modification of training modules based on input and lessons learned.
5. On-line webinar training module ready for ongoing use by California jurisdictions.
6. Establishment of "help-line" support and a billing workgroup for California.
7. Establishment of at least one state contract with an insurance company for immunization services, if feasible.
8. Completion of a centralized system utilizing the Immunization Registry to track doses of 317 vaccine that is reimbursed to local health jurisdictions by private insurance, so reimbursement can be used by the State to re-purchase additional vaccine.
9. Completion of a plan for conversion to ICD-10 diagnosis codes.
10. Completion of a written evaluation of the implementation plan.

GLOSSARY OF TERMS COMMONLY USED BY MEDICAL INSURANCE COMPANIES

Admitting privileges: Is a right granted to a doctor to admit patients to a particular hospital.

Aged accounts receivable: Outstanding claims for services rendered that are not paid or no explanation of benefits (EOB) is sent by the payor within the usual 45 days of claim submittal.

Ancillary services: These are services that are supplemental services such as laboratory, x-rays and physical therapy.

Assignment of benefits: A signed authorization by the insured or legal guardian to reassign the payments to the LHD.

Average wholesale price: is a prescription drugs term referring to the average price at which drugs are purchased at the wholesale level.

Beneficiary: A person who is eligible for receiving benefits under an insurance policy.

Birthday rule: A method used by health insurance carriers to determine which parent's health insurance coverage will be primary for a dependent child, when both parents have separate coverage. The birthday of the parent that falls closest to the beginning of the year is the primary insurance carrier.

Board certified: A physician has taken and passed a medical specialty examination. There are numerous types of boards.

Coinsurance: The amount an insured is responsible for on covered medical services after the deductible or copayment required by the health insurance plan. This is typically a percentage amount of their allowable charges.

Contractual obligation: an agreement with specific terms between two or more persons or entities in which there is a promise to do something in return for a valuable benefit known as consideration.

Coordination of benefits (COB): The practice of ensuring that insurance claims are not paid multiple times, when an enrollee is covered by two health plans at the same time.

Copayment (Copay): A portion of the charges a patient would be responsible for.

Deductible: It is a dollar amount of which the insured is responsible for before the healthcare benefits take effect. As a general rule (there are exceptions) PPO plans are the ones who have a deductible for their insured. It is a yearly out of pocket expense for the insured.

Denial: Is the refusal to pay for a specified service or claim.

Dependent: a family member or other person who is supported financially by another, especially one living in the same house.

Exclusive Provider Organization (EPO): This is an exclusive provider network and an insured member will utilize the doctors and hospitals within the EPO network. There are no out of network benefits.

Explanation of benefits (EOB): A summary statement sent from the health insurance plan to the insured subscriber and the healthcare provider who billed the services on how they processed the charges. It also indicates the total benefit payment they made or denied as well as the amount insured's responsible for.

Fee for service (FFS): A payment system where the professional services in which the provider performs is paid.

Group health plan: A plan that provides insurance coverage for an organization's employees or members.

Health maintenance organization (HMO): The HMO plans offer full scope of healthcare services through a network of providers that contract exclusively with the HMO, or who agree to provide the services to members at a pre-negotiated rate.

Independent physician association (IPA): An organization of physicians who may have separate offices but who negotiate contracts with insurance companies and healthcare groups/departments. They can be found on the health insurance plan's online directory.

Insured: Is a person who is covered by an insurance plan or policy.

Major medical plan: This plan is a high-limit, high deductible plan to cover catastrophic illness or injury.

Medical necessity: This is accepted healthcare services and supplies provided by healthcare providers appropriate to the evaluation and treatment of a disease, condition, illness or injury consistent with standard of care.

Medicare supplement insurance (aka Medigap): This is a plan that supplements the coverage provided by Medicare benefits. These plans sometimes pay for the insured's deductibles or coinsurance amounts.

National Drug Code (NDC): a unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identifies the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

Network provider: Providers who are contracted to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates

Out of plan network: This refers to physicians, hospitals or other healthcare providers who are considered nonparticipants of the health insurance plan. There is no contract between the health insurance plan and the provider.

Out of pocket: It is the amount of money an insured has to pay for medical services after the insurance carrier has paid.

Out of pocket maximum: This is an annual limitation on all cost-sharing for which the insured is responsible for under the insurance plan.

Point of service (POS): The POS plan have a two tier plan that consists of HMO and PPO plans.

Preferred provider organization (PPO): An organization of physicians, hospitals and other healthcare providers whose members discount their healthcare services to the insured patients. The members of the PPO are referred to as “preferred providers”.

Reasonable and customary fees (usual and customary fees): The amount of what the insurance has established as the normal range for a specific medical service performed within a geographic area.

Referral: The process of sending patients to another doctor or medical professional, and to the actual paper authorizing the visit. In HMOs and other managed care systems, a referral is usually necessary to see any practitioner or specialist other than your primary care physician (PCP), if you want the service to be covered. The referral is obtained from your PCP, who may require a telephone or office consultation first.

Self-insured: An individual or businesses who take on the risk for themselves or their employees' medical costs with the purchase of a health insurance plan. Plans available can either cap the total amount that they pay out or have high-deductible where the individual or the individual takes on a large amount of the financial risk, and the insurance company pays the rest.

Service area: Refers to an area where a health plan accepts members. It means the area where a service under a particular plan is offered. Each plan has a network area within which a member of the plan must consult the service provider. If a patient goes to a service provider outside the plan except in case of an emergency, then s/he will not receive any benefits under the plan. Even a travel outside a plan's service area would disentitle a beneficiary from benefits and s/he will be disenrolled from the plan.

Share of cost (SOC): A Medi-Cal beneficiary's monthly amount of financial responsibility before the benefits takes effect. This is on a month to month basis.

Appendix A: Instructions for Obtaining a NPI Number

The NPI registry enables you to search for a provider's information. Before applying for an NPI for each of your providers, you should check the registry first. It is common for providers to have been assigned an NPI through a previous employer. To search the registry, go to the National Plan and Provider Enumeration system (NPPES) site <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, Click on the "Search the NPI Registry".

NPPES
National Plan & Provider Enumeration System

[Help](#)

National Plan and Provider Enumeration System (NPPES)

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the **National Plan and Provider Enumeration System (NPPES)** to assign these unique identifiers.

The website works best in Internet Explorer versions 6.0 and higher and Firefox versions 2.0 and higher. Users may experience issues with other browsers and are recommended to use the browsers listed above. It is recommended that browser windows be opened using the icon on the desktop to avoid shared browser sessions. Some browsers share sessions regardless of how the browser is opened. Please check with the browser's vendor about session management. When NPPES detects multiple browsers open within the same session, NPPES will terminate the session to protect the data in NPPES. Data entered will be lost and will need to be re-entered.

If you are a **Health Care Provider**, you must click on [National Provider Identifier \(NPI\)](#) to login or apply for an NPI.

A standard identifier has not yet been adopted for health plans.

Search the NPI Registry. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Business Name. There is no charge to use the NPI Registry.

About NPPES....
CMS has contracted with Cognosante, LLC. to serve as the NPI Enumerator.
The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in NPPES.
The NPI Enumerator may be contacted as follows:

By phone: 1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)	By e-mail at: customerservice@npienumerator.com	By mail at: NPI Enumerator PO Box 6059 Fargo, ND 58108-6059
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Centers for Medicare & Medicaid Services Department of Health and Human Services

For the group or lab NPI click on "**Organizational Provider**", and for an individual provider, click on the "**Individual Provider**".

NPPES
National Plan & Provider Enumeration System

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NPI Registry

The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Business Name. There is no charge to use the NPI Registry.

Some health care providers reported their SSNs, IRS ITINs or EINs in sections of the NPI application that contain information that is required to be disclosed under FOIA. For example,

1. Providers who are individuals may have reported SSNs or IRS ITINs in FOIA-disclosable fields (such as in the "Other Provider Identifiers" or "License Number" fields).
2. An incorporated individual, when applying for an NPI for the corporation, may have reported his/her SSN as the EIN of the corporation.

CMS has urged health care providers to review their NPPES FOIA-disclosable data to ensure that it is correct and to remove any inappropriate or sensitive information that they may have reported in any of those fields that are "optional" (i.e., not required to be furnished) and/or replace the inappropriate or sensitive information that they may have reported in required fields with the appropriate information. If health care providers did not remove SSNs, IRS ITINs or EINs from FOIA-disclosable fields, CMS took action to not disclose any SSNs or IRS ITINs that were entered in those fields. CMS also took action to temporarily suppress reported EINs, even though they are disclosable under FOIA, because providers reported SSNs in the EIN field. After April 21, 2008, CMS will mask SSNs, IRS ITINs, and EINs when these numbers are entered in the Other Provider Identifier Number and License Number fields as follows: SSNs to "SSSSSSSS", IRS ITINs to "*****", and EINs to "===== ". This action also includes the continued suppression of the EINs and the suppression of the Subpart Parent Organization TINs of all Organizations in the NPI Registry. CMS expects to lift the suppression of EINs and Parent Organization TINs in the future.

Search the NPI Registry

- Search for an [Individual Provider](#)
- Search for an [Organizational Provider](#)

Additional Resources:
[Frequently Asked Questions](#)
[CMS NPI Page](#)

Enter as much of the providers information as possible in the requested fields and hit the search button. It is also a good idea to check under other names such as maiden names or aliases. If your staff indicates they already have an existing NPI, this is where you will enter the number to validate.

NPPES
 National Plan & Provider Enumeration System

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NPI Registry Search

Please enter data for at least one of the following fields. If searching on Practice Address State, you must enter data for at least one other field. To perform a wild card search, at least two characters must be entered before the "****". For example, to search for data beginning with "Ch", enter "Ch****". Wild card searches are only available on the Provider First Name, Provider Last Name and Practice Address City fields.

Information in the NPI Registry is updated daily.

NPI:

Provider First Name:

Provider Last Name:

Practice Address City:

Practice Address State:

Practice Address Zip:

If the provider has an existing NPI, you will see the necessary information you will need to enter for your billing system.

The information for the Provider you selected is displayed. The NPI Registry data was last updated on 12/25/2011. [Back to Results](#)

NOTE: Some health care providers reported their SSNs or IRS ITINs in sections of the NPI application that contain information that is required to be disclosed under FOIA. For example, a provider may have reported an SSN or an IRS ITIN as an "Other Provider Identification Number" or as a "License Number". To protect the privacy of these individuals, we have made every attempt to locate and remove those SSNs and IRS ITINs from being displayed in the information provided below.

Provider Information:

Name: MRS. CENSE LORRAINE SMITH R.N., PHN
 Gender: FEMALE
 Sole Proprietor: NO

NPI Information:

NPI: 162952077
 Entity Type: INDIVIDUAL
 Enumeration Date: 12/29/2007
 Last Update Date: 12/29/2007
 Replacement NPI:
 Deactivation Date:
 Reactivation Date:

Provider Business Mailing Address:

Address: 1800 MOUNT VERNON AVE
 BAKERSFIELD, CA 93306-3302
 Phone Number: 6618681602
 Fax Number: 6618681218

Provider Business Practice Location Address:

Address: 1800 MOUNT VERNON AVE
 BAKERSFIELD, CA 93306-3302
 Phone Number: 6618681602
 Fax Number: 6618681218

Provider Taxonomy:

Primary Taxonomy	Selected Taxonomy	State	License Number
YES	153WC1503L - REGISTERED NURSE - COMMUNITY HEALTH	CA	RN032965

Other Provider Identifier:

Issuer	Number	State	Issuer

PROVIDER INFORMATION

NPI INFORMATION

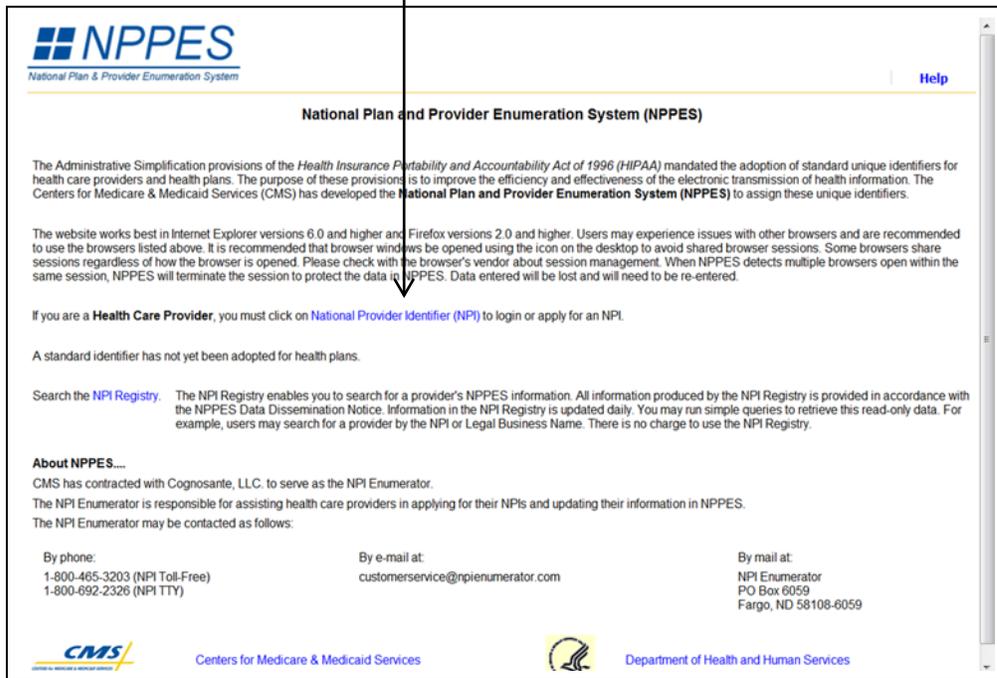
PROVIDER BUSINESS ADDRESS

PROVIDER PRACTICE LOCATION

PROVIDER LICENSE NUMBER

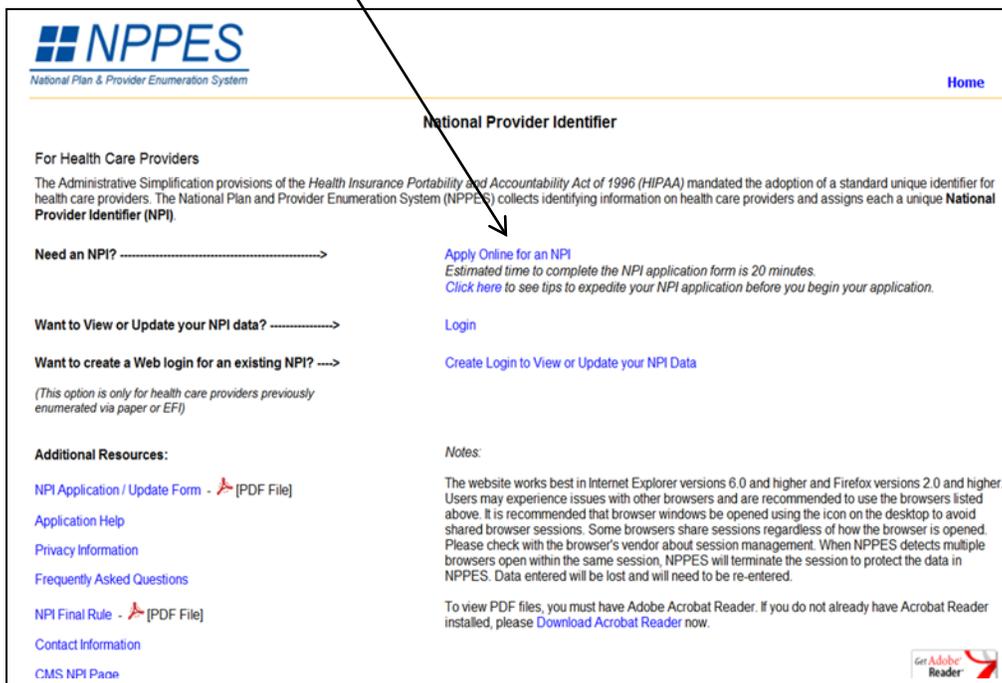
TAXONOMY CODE

To apply for a new NPI, click on the “**National Provider Identifier (NPI)**”



The screenshot shows the NPPES homepage. At the top left is the NPPES logo with the tagline "National Plan & Provider Enumeration System". At the top right is a "Help" link. The main heading is "National Plan and Provider Enumeration System (NPPES)". Below this is a paragraph explaining that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. Another paragraph states that the website works best in Internet Explorer versions 6.0 and higher and Firefox versions 2.0 and higher. A third paragraph says that if you are a Health Care Provider, you must click on National Provider Identifier (NPI) to login or apply for an NPI. Below this is a section for "About NPPES...." which mentions that CMS has contracted with Cognosante, LLC. to serve as the NPI Enumerator. At the bottom, there are contact details: "By phone: 1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)", "By e-mail at: customerservice@npienumerator.com", and "By mail at: NPI Enumerator PO Box 6059 Fargo, ND 58108-6059". Logos for CMS and the Department of Health and Human Services are also present.

Then click on “**Apply Online for an NPI**”.



The screenshot shows the "National Provider Identifier" page. At the top left is the NPPES logo with the tagline "National Plan & Provider Enumeration System". At the top right is a "Home" link. The main heading is "National Provider Identifier". Below this is a section for "For Health Care Providers" which explains that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of a standard unique identifier for health care providers. The main content area has three sections: "Need an NPI?" with a right-pointing arrow and a link to "Apply Online for an NPI" (with subtext: "Estimated time to complete the NPI application form is 20 minutes. Click here to see tips to expedite your NPI application before you begin your application."), "Want to View or Update your NPI data?" with a right-pointing arrow and a link to "Login", and "Want to create a Web login for an existing NPI?" with a right-pointing arrow and a link to "Create Login to View or Update your NPI Data". Below these is an "Additional Resources:" section with links for "NPI Application / Update Form - [PDF File]", "Application Help", "Privacy Information", "Frequently Asked Questions", "NPI Final Rule - [PDF File]", "Contact Information", and "CMS NPI Page". A "Notes:" section contains browser compatibility information and a note about Adobe Acrobat Reader. At the bottom right is the Adobe Reader logo.

Read Step 1 and Step 2, then click on the Begin Application Form Button.

Note: Use of Back and Forward browser buttons could result in loss of all the information entered. Users should use the Next and Previous buttons provided on the application to navigate between the pages of the application.

Step 1: Before you begin, make sure you have the following information.
This information will be required to complete the NPI Application Form.
You will not be able to save your work if you quit before you have completed the application form.

- Information Required for Individual Providers**
 - Provider Name
 - SSN (or ITIN if not eligible for SSN) ²
 - Provider Date of Birth
 - Country of Birth
 - State of Birth (Country of Birth is U.S.)
 - Provider Gender
 - Mailing Address
 - Practice Location Address and Phone Number
 - Taxonomy (Provider Type) ⁴
 - State License Information ¹
 - Contact Person Name
 - Contact Person Phone Number and E-mail
- Information Required for Organizations**
 - Organization Name
 - Employer Identification Number (EIN) ³
 - Name of Authorized Official for the Organization
 - Phone Number of Authorized Official for the Organization
 - Organization Mailing Address
 - Practice Location Address and Phone Number
 - Taxonomy (Provider Type) ⁴
 - Contact Person Name
 - Contact Person Phone Number and E-mail

¹ (required for certain taxonomies only)
² (SSN or ITIN information should only be reported in the SSN or ITIN field)
³ Do not report an SSN or IRS ITIN in the EIN field
⁴ Provider Taxonomy codes can be obtained from <http://www.hhs.gov/ncies/codes/taxonomy>

Online Help is available from each page of the Application / Update Form by clicking "Help" at the top right of the page.

If you need additional help or have any questions concerning your application, contact the NPI Enumerator:

NPI Enumerator Contact Information

By phone: 1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)	By e-mail at: customerservice@npienumerator.com	By mail at: NPI Enumerator PO Box 6059 Fargo, ND 58108-6059
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Step 2: Read the information below.
You must agree to the terms below when you submit your application.

I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I understand that the information provided in this application may be used by other agencies in accordance with privacy regulations.

I have read and understand the Privacy Act Statement.

I have read and understand the Penalties for Falsifying Information on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.

Penalties for Falsifying Information on the NPI Application / Update Form:
18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Step 3: Begin online application.

Complete the application security check questions.

NPPES
National Plan & Provider Enumeration System

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Application Security Check

★Indicates Required Field

This security check is used to prevent the creation of fictitious accounts. Please provide answers to the 2 security questions listed below.

Questions	Answers
★From what material is a leather coat made?	<input type="text"/>
★Which is more likely to sink in water: a rock or a bubble? (Hint: Rock, Bubble)	<input type="text"/>

Create a User ID and password for future access to NPI and answer all 5 security questions. These are questions that each individual provider should remember if they need to change anything in the database. The NPI number will follow the provider. For example, if the provider moves to another city, gets a job at a new site, or has a name change, the information will need to be updated in this database. Some individual providers may have one NPI number, but

provides services at two different clinics. In this scenario, the same NPI number will be used, and when the agency submits the bill to the insurance carrier, they will be identified by location, Tax ID, and group NPI number.

The screenshot shows the 'NPI Application Form - Create NPI User ID and Password' page. At the top left is the NPPES logo with the tagline 'National Plan & Provider Enumeration System'. At the top right are links for 'Home' and 'Help'. The main heading is 'NPI Application Form - Create NPI User ID and Password'. Below this, it says 'Please create a User ID and password for future access to NPI:'. A red asterisk indicates required fields. The form includes: 'NPI User ID' (text input), 'NPI Password' (text input), and 'Retype NPI Password' (text input). A note states: 'Note: Personal information, such as a Social Security Number, should not be used as the User ID. The User ID can contain a maximum of four digits. Please note: The User ID cannot be changed.' Below the password fields are five sets of 'Select Secret Question' (dropdown menus) and 'Answer' (text inputs). A 'Next >' button is at the bottom.

For an individual provider (ie Medical Doctor, Nurse, Nurse Practitioner, Licensed Vocational Nurse) choose Type 1 and click the next button.

The screenshot shows the 'NPI Application Form - Select Entity Type' page. At the top left is the NPPES logo with the tagline 'National Plan & Provider Enumeration System'. At the top right are links for 'Logoff' and 'Help'. The main heading is 'NPI Application Form - Select Entity Type'. Below this, it says 'Please select the radio button which most applies to you or your organization:'. There are two radio button options: 'Type 1: An individual who renders health care services. (Example: Dentist, Chiropractor, Pharmacist)' and 'Type 2: An organization that renders health care services. (Example: Hospital, Nursing Facility, Pharmacy)'. A 'Next >' button is at the bottom. A note at the bottom states: 'Note: Please use the Next button to navigate to the next page in the application.'

Complete the Provider Name Information section and other identifying information section.
Make sure to fill out all fields marked with a red asterisk.

NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- Provider Profile
- Mailing Address
- Practice Location
- Other Identifiers
- Taxonomy
- Contact Person
- Certification

NPI Application Form - Provider Profile

Provider Name Information: * Indicates Required Field

Prefix: * First: Middle: * Last: Suffix:

Credential(s): (M.D., D.O., etc.)

Other Name: (if applicable)

Prefix: First: Middle: Last: Suffix:

Credential(s): (M.D., D.O., etc.) Type of Other Name:

Other Identifying Information:

* Date of Birth: (MMDD/YYYY) * Social Security Number: (Without Dashes)

State of Birth: (* If U.S.) * Country of Birth: United States

* Gender: Male Female

* Is the Provider a Sole Proprietor? Yes No

Next >

Answer no for Sole Proprietor. A sole proprietor is a form of business in which one person owns all the assets of the business and is solely liable for all the debts of the business in an individual capacity.

Enter mailing address information. This information will assist NPPES in contacting you with any questions they may have regarding your application for an NPI or with other

NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- Provider Profile
- Mailing Address
- Practice Location
- Other Identifiers
- Taxonomy
- Contact Person
- Certification

NPI Application Form - Business Mailing Address

If your address is outside the U.S., click here: Foreign Address

If your address is military address, click here: Military Address

* Indicates Required Field

Domestic Business Mailing Address Information

* Address Line 1: (Street Number and Name)

Address Line 2: (e.g. Suite Number)

* City: * State: * Zip + 4

Country: United States

Phone Number: Extension: Fax Number: (Without Dashes)

< Previous Next >

Note: Please use the Previous and Next buttons to navigate between the pages in the application.

information regarding NPI. You must provide an address and telephone number where they can

contact you directly to resolve any issues that may arise during the review of your application.

Do not report your residential address in this section unless it is also your business mailing

address. You will be asked to accept standardization for the address you entered. At this point you can accept, reject or revalidate the address location. The

NPPES
National Plan & Provider Enumeration System

Application Sections

- Provider Profile
- Mailing Address**
- Practice Location
- Other Identifiers
- Taxonomy
- Contact Person
- Certification

NPI Application Form - Business Mailing Address Standardization

In order to ensure the optimum performance of the National Provider System, we standardize all addresses; for example, we change "Avenue" to "Ave." This makes it easier to find your information again in the future and to ensure that we do not have duplicate entries where they should not occur.

Your standardized address is:
1800 Mount Vernon Ave
Bakersfield CA 93306 - 3302

Please do one of the following:

- Accept the standardized address.
- Reject the standardized address and keep your input as is.
Note: Rejecting standardized address will delay enumeration
- Modify your input in the boxes below and submit for revalidation.

* Indicates Required

* Address Line 1: (Street Number and Name) 1800 Mt Vernon Ave

Address Line 2: (e.g. Suite Number)

* City, State, Zip: Bakersfield CA - CALIFORNIA 93306

Accept Standardized Address Use Input Address Revalidate Address

standardization process makes the search for your information easier and ensures that duplication entries do not occur.

Other Identification section is where you will enter any other identifiers the provider might have. Do not report Social Security numbers, or Tax ID numbers in this section. If the provider

does not have any other identifiers, click next and move to the next section.

NPPES
National Plan & Provider Enumeration System

Application Sections

- Provider Profile
- Mailing Address
- Practice Location
- Other Identifiers**
- Taxonomy
- Contact Person
- Certification

NPI Application Form - Other Identification Numbers

Please Enter All Other Provider Identifiers (Medicare UPIN, Medicare PIN, Medicare OSCAR/Certification, Medicare NSC, Medicaid, and Other):

Note: These numbers will be of use in matching your NPI record to insurers' records so you can continue to be recognized by insurers. If you don't have such numbers, you are not required to obtain them. DO NOT report the Social Security Number (SSN) or IRS Individual Taxpayer Identification Number (ITIN) in this section.

Add Identifier

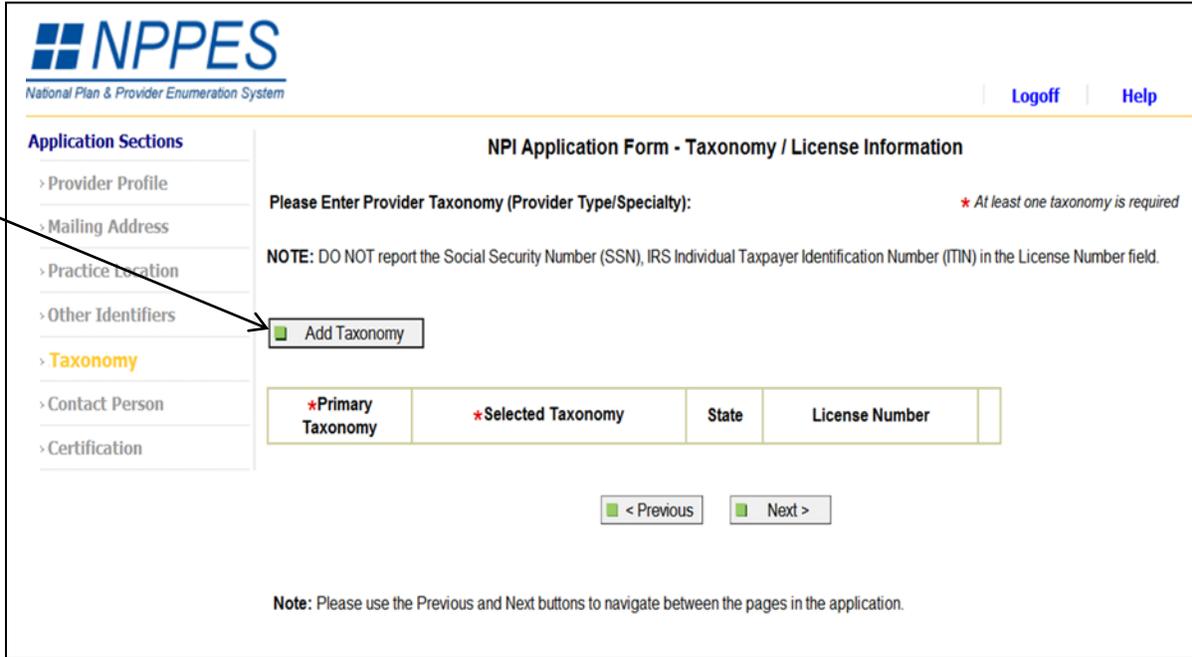
Select All Clear Selected Delete

Issuer	Number	State	Issuer
--------	--------	-------	--------

< Previous Next > Delete

Note: Please use the Previous and Next buttons to navigate between the pages in the application.

A primary taxonomy code must be selected in order to facilitate reporting of providers by classification. Click the Add Taxonomy button then next.



NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- > Provider Profile
- > Mailing Address
- > Practice Location
- > Other Identifiers
- > **Taxonomy**
- > Contact Person
- > Certification

NPI Application Form - Taxonomy / License Information

Please Enter Provider Taxonomy (Provider Type/Specialty): * At least one taxonomy is required

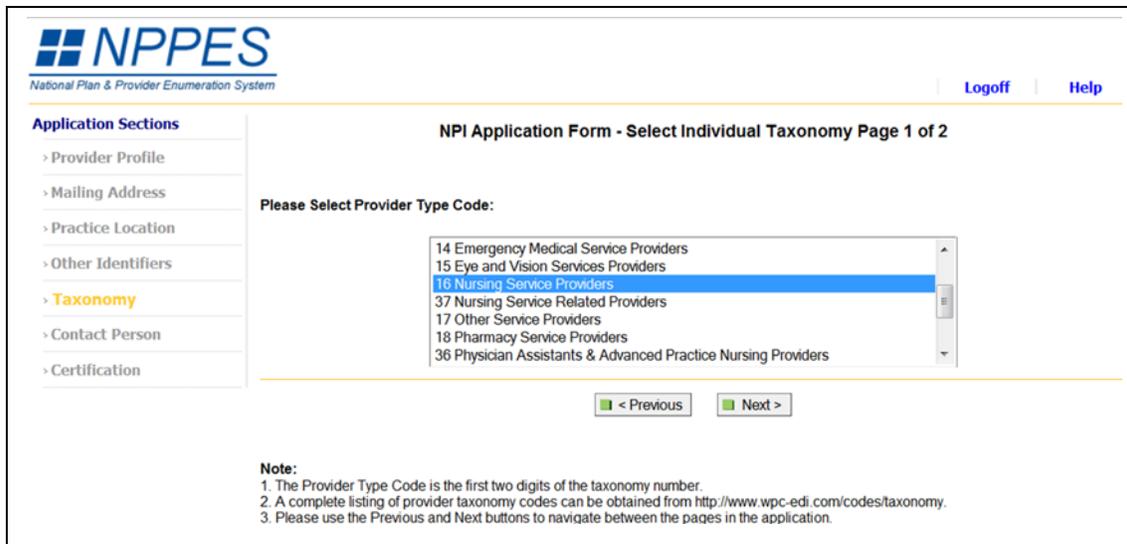
NOTE: DO NOT report the Social Security Number (SSN), IRS Individual Taxpayer Identification Number (ITIN) in the License Number field.

*Primary Taxonomy	*Selected Taxonomy	State	License Number
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< Previous Next >

Note: Please use the Previous and Next buttons to navigate between the pages in the application.

Choose your taxonomy code according to your provider type and click next.



NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- > Provider Profile
- > Mailing Address
- > Practice Location
- > Other Identifiers
- > **Taxonomy**
- > Contact Person
- > Certification

NPI Application Form - Select Individual Taxonomy Page 1 of 2

Please Select Provider Type Code:

- 14 Emergency Medical Service Providers
- 15 Eye and Vision Services Providers
- 16 Nursing Service Providers
- 37 Nursing Service Related Providers
- 17 Other Service Providers
- 18 Pharmacy Service Providers
- 36 Physician Assistants & Advanced Practice Nursing Providers

< Previous Next >

Note:
1. The Provider Type Code is the first two digits of the taxonomy number.
2. A complete listing of provider taxonomy codes can be obtained from <http://www.wpc-edi.com/codes/taxonomy>.
3. Please use the Previous and Next buttons to navigate between the pages in the application.

Choose the correct classification number and enter any relevant license numbers.

NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- > Provider Profile
- > Mailing Address
- > Practice Location
- > Other Identifiers
- > **Taxonomy**
- > Contact Person
- > Certification

NPI Application Form - Select Taxonomy Page 2

You have selected Provider Type: **17 Other Service Providers**

Please Continue Your Taxonomy Selection:

Classification Name - Area of Specialization

- 172A00000X - Driver -
- 176P00000X - Funeral Director -
- 170300000X - Genetic Counselor, MS -
- 174H00000X - Health Educator -**
- 175L00000X - Homeopath -
- 171R00000X - Interpreter -
- 174N00000X - Lactation Consultant, Non-RN -

Please Enter Your State License Information For Your Taxonomy Selection:

NOTE: DO NOT report the Social Security Number (SSN), IRS Individual Taxpayer Identification Number (ITIN) in the License Number field.

License Number: State Where Issued:

< Previous Save & Add Another Save

Note: Please use the Previous and Save buttons to navigate between the pages or save the application.

Review to ensure that the information is correct. Check the Primary Taxonomy box and click next.

NPPES
National Plan & Provider Enumeration System

Logoff Help

Application Sections

- > Provider Profile
- > Mailing Address
- > Practice Location
- > Other Identifiers
- > **Taxonomy**
- > Contact Person
- > Certification

NPI Application Form - Taxonomy / License Information

Please Enter Provider Taxonomy (Provider Type/Specialty): * At least one taxonomy is required

NOTE: DO NOT report the Social Security Number (SSN), IRS Individual Taxpayer Identification Number (ITIN) in the License Number field.

Add Taxonomy

*Primary Taxonomy	*Selected Taxonomy	State	License Number	
<input checked="" type="checkbox"/>	174H00000X - Health Educator -			Delete

< Previous Next >

Note: Please use the Previous and Next buttons to navigate between the pages in the application.

Enter the contact person information. This information is the person assigned to credential medical staff for your department. They will need to be able to answer questions regarding the information furnished in the application.

The screenshot shows the 'NPI Application Form - Contact Person Information' page. On the left is a sidebar with 'Application Sections' including Provider Profile, Mailing Address, Practice Location, Other Identifiers, Taxonomy, Contact Person (highlighted), and Certification. The main content area has a title 'NPI Application Form - Contact Person Information' and a 'Logoff | Help' link. Below the title is a section for 'Contact Person Name' with a 'Same As Provider' checkbox. A note says 'If you would like to designate an alternate contact person, please fill out the following:'. This is followed by fields for Prefix, First, Middle, Last, and Suffix, and fields for Credential(s) and Title. Below that is a section for 'Please Complete The Following Additional Information For The Contact Person:' with a note to use mailing or practice phone. It includes checkboxes for 'Same As Mailing Phone' and 'Same As Practice Phone', and fields for Contact Person Phone Number (with extension) and Contact Person E-mail (with a retype field). A note states 'All notifications will be sent to the Contact Person E-mail provided on this page.' At the bottom are '< Previous' and 'Next >' buttons.

Read the Certification statement and check the box if you agree and click the submit button.

The screenshot shows the 'NPI Application Form - Certification Statement' page. The sidebar on the left has 'Application Sections' including Provider Profile, Mailing Address, Practice Location, Other Identifiers, Taxonomy, Contact Person, and Certification (highlighted). The main content area has a title 'NPI Application Form - Certification Statement' and a 'Logoff | Help' link. Below the title is a checkbox labeled 'Check this box to indicate that you certify to the following:'. This is followed by three paragraphs of text: 'I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.', 'I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.', and 'I have read and understand the Privacy Act Statement.' Below this is a section titled 'Penalties for Falsifying Information' with a paragraph of text: '18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.' At the bottom are '< Previous' and 'Submit' buttons. A note at the very bottom says 'Please use the Submit button to submit the application or the Previous button to navigate between pages in application.'

This is your confirmation. You will see a tracking number associated with this application, and the contact person will receive the assigned NPI within 2-14 days.



National Plan & Provider Enumeration System

[Logoff](#) | [Help](#)

Thank you. Your application will be processed.

Application processing times may vary based on current inventories. If you have any questions regarding this application or if the designated contact person does not receive the provider's NPI via email within 15 working days, please contact the NPI Enumerator at 1-800-465-3203 (NPI Toll-Free).

Provider Name: Mr. Patrick Joe Grijalva B.A.
Your tracking number is: 12282011721632

Please provide this tracking number on all correspondence.

Please print this page for your records.

Clicking this button will allow you to view and print the information furnished on your application.
Please Note: This page/printout may contain sensitive information.

NPI Enumerator Contact Information

By phone: 1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)

By e-mail at: customerservice@npienumerator.com

By mail at: NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

For your reference, please print this page by clicking the Print icon, located in your browser's toolbar.

Appendix B: Sample Intent Letters

May 7, 2010

Managed Care Systems
Attention: Florita Perez
4550 California Ave. Ste. 500
Bakersfield, CA. 93309

SUBJECT: Letter of Intent for Contractual Agreement between County of Kern, Department of Public Health Services ("KCDPHS") and Managed Care Systems

Kern County Department of Public Health Services requests consideration for becoming a contracted provider with Managed Care Systems.

KCDPHS has a full spectrum body of clinics located throughout urban and rural Kern County serving the public's need for varied and specialized services. Services include sexually transmitted infection testing and treatment, confidential HIV/AIDS testing and counseling, well-child and child health disability prevention screenings, head lice/scabies examination and treatment, family planning – education/counseling and treatment, immunizations for adults and children, travel vaccination and information, pregnancy testing and counseling, Tuberculosis clinic and case management.

Our multiple district clinics create unique geographic accessibility to Kern County residents and are located as follows:

- Bakersfield - 1800 Mt. Vernon Ave., 661-868-0306
- North of the River - 125 El Tejon Ave., 661-868-5250
- Lake Isabella - 7050 Lake Isabella Blvd., 760-549-2090
- Lamont - 12014 Main Street 661-868-5824
- Mojave - 1775 Hwy 58, 661-824-7066
- Ridgecrest - 250 W. Ridgecrest Blvd., 760-375-5157
- Shafter - 329 Central Valley Hwy., 661-746-7562
- Taft - 315 Lincoln, 661-763-8591
- Tehachapi - 125 East "F" Street, 661-822-3005
- Wasco - 810 8th Street, 661-758-3006
- Arvin - 204 S. Hill St. 661-854-5411
- Delano - 455 Lexington Ave., 661-721-3820

If you have questions, please do not hesitate to call me at 661-868-0300.

Respectfully submitted,

Matthew Constantine
Director of Public Health Services

April 26, 2011

Aetna
Attn: Barbra
151 Farmington Avenue
Hartford, CT 06156

SUBJECT: Letter of Intent for Contractual Agreement between County of Kern, Department of Public Health Services Clinic ("KCDPHS") and AETNA

Kern County Department of Public Health Services Clinic requests consideration for becoming a contracted provider with AETNA.

KCDPHS Clinic and our multiple outlying district clinics have an array of services that would provide convenient, efficient and reasonably priced benefits to Aetna patients. Sensitive services such as family planning and sexually transmitted disease testing and treatments are provided to the public by the KCDPHS clinic. Many patients come to the KCDPHS Clinic as they hesitate to go to their private providers for socially sensitive services. Local private Doctors commonly refer patients to us for vaccine services, as many private providers are not able to keep the amount of vaccine inventory that is available in our clinic. In addition, Kern County has a large number of parents bringing their children to the KCDPHS Clinic for their back to school vaccines.

The KCDPHS Clinic currently averages over 2000 patients a month, many of whom have private insurance. Aetna patients are already coming to KCDPHS because of one or more of the above stated reasons. When determining Aetna patient plan benefits, there is a variety of scenarios involving higher out of pocket expense for deductibles and coinsurance as a non-preferred provider or no out of network benefits. As a contracted provider we will provide an increase in customer satisfaction as well as being a convenient local referral for your network Doctors.

Services provided:

- 1. Immunization of adults and children (Full inventory of vaccines)**
- 2. HIV/AIDS testing and counseling**
- 3. Family Planning education/counseling and treatment**
- 4. Travel Vaccination and information**
- 5. Pregnancy testing and counseling**
- 6. Tuberculosis and case management**
- 7. STD testing and treatment**

Our multiple district clinics create unique geographic accessibility to AETNA patients and are located as follows:

- Bakersfield - 1800 Mt. Vernon Ave., 661-868-0306
- North of the River - 125 El Tejon Ave., 661-868-5250
- Lake Isabella - 7050 Lake Isabella Blvd., 760-549-2090

- Lamont - 12014 Main Street 661-868-5824
- Mojave - 1775 Hwy 58, 661-824-7066
- Ridgecrest - 250 W. Ridgecrest Blvd., 760-375-5157
- Shafter - 329 Central Valley Hwy., 661-746-7562
- Taft - 315 Lincoln, 661-763-8591
- Tehachapi - 125 East "F" Street, 661-822-3005
- Wasco - 810 8th Street, 661-758-3006
- Arvin - 204 S. Hill St. 661-854-5411
- Delano - 455 Lexington Ave., 661-721-3820

If you have questions, please do not hesitate to call me at 661-868-0300.

Respectfully submitted,

Matthew Constantine
Director of Public Health Services

Appendix C: Sample Board Letter for Contract Approval

December 13, 2011

Board of Supervisors
Kern County Administrative Center
1115 Truxtun Avenue
Bakersfield, CA 93301

**PROPOSED INDEPENDENT PHYSICIAN & PROVIDER AGREEMENT WITH
BLUE SHIELD OF CALIFORNIA FOR REIMBURSEMENT OF COVERED SERVICES
CONTAINING NON-STANDARD TERMS
(Fiscal Impact: Unknown)**

The purpose of this letter is to request your Board's approval of the proposed Independent Physician & Provider Agreement with California Physician's Service dba Blue Shield of California (BSC) for reimbursement of covered services provided to BSC members.

The Department provides mandated public health services to the community. These services are eligible for reimbursement as described within the California Department of Health Care Services Medi-Cal rates. When recipients of these services are covered under private insurance carrier health plans, the carrier is required to contract with a provider in order to reimburse for services rendered. The purpose of this Agreement is to enable the Department to bill BSC for services rendered through the Public Health Services Department, Health Officer's Clinic and the Public Health Laboratory. The ability to bill a licensed health care plan will result in increased revenues.

This Agreement has been reviewed by County Counsel and has been determined to contain non-standard terms which must be presented to your Board for approval. Counsel has advised the Department to place this item on the Agenda as a non-consent item and identify the non-standard terms in accordance with the guidelines recently approved by this Board.

BSC is licensed as a health care services plan under the California Knox-Keene Health Care Service Act. The Knox-Keene Act requires health plans to include certain non-negotiable language within the agreements between the health plans and their providers. The wording in question is standard language across all insurance companies and cannot be modified. The Department has nevertheless attempted to negotiate with BSC to modify the provisions within the proposed agreement that the Office of County Counsel has identified as being objectionable. The Department's efforts in this regard have been unsuccessful due to BSC's requirement to comply with the terms of the California Knox-Keene Health Care Services Act.

Counsel recommended the following:

1. In section 7. Term & Termination, the deletion of the provision for automatic renewal of the term of the agreement after the expiration of the original one year term; and the addition of non-appropriation language for immediate termination by Provider. This is an evergreen provision. However, the Department has internal mechanisms to regulate and provide advance notice of the need to terminate this Agreement. These mechanisms are structured into the

Department's processes. In addition, Counsel has identified language contained within section 7.3 that allows for immediate termination by mutual agreement if it is determined that the Department is incapable, because of lack of funding, staffing and/or other resources to continue providing services pursuant to the Agreement. For these reasons it is the opinion of staff and Counsel that the inclusion of this language does not pose an unreasonable risk to the County.

2. In section 8. Resolution of Disputes, the deletion of Arbitration of Disputes. This is a non-negotiable requirement of the Knox-Keene Act. It is the opinion of staff and Counsel that because this Agreement is one in which the Department is providing the services, and that the services proposed are relatively non-invasive, that the risk to the County is minimal. Therefore, the potential of going to arbitration is slight, at best.

Failure to approve this request will eliminate the Department's ability to access an available and reliable revenue resource. Given the importance of the program and the opinions of staff and Counsel, the provisions described above do not pose an unreasonable risk to the County; it is the Department's request that your Board approve the Agreement as presented.

Therefore, it is RECOMMENDED that your Board approve and authorize the Chairman to sign the proposed Agreement containing non-standard terms in substantially the form submitted, subject to approval as to final form by County Counsel, with Blue Shield of California for reimbursement of covered services provided to members of the Blue Shield of California health plan.

Respectfully submitted,

Matthew Constantine

Director of Public Health Services

MC

Attachments

C: Each Supervisor
County Administrative Office