Immunization Billing for Public Health

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Disclaimer: The materials for this paper are for informational purposes only. Information within this paper does not constitute legal or business advice. Information in this paper is provided without warranty of any kind, either expressed or implied, including but not limited to, the implied warranties of fitness for a particular purpose. Most of this white paper will focus on immunization billing for public health in the State of Illinois. Many policies, procedures, and codes will vary based on individual departments, services offered, and individual situations. It is the responsibility of every local health department to verify information as it pertains to their own individual department.
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Executive Summary

Public health services have traditionally been viewed as free, and a move toward billing for these services requires a paradigm shift for both Local Health Department (LHD) staff and individuals seeking services. For LHDs, billing is a comprehensive approach and not isolated to just one clinical service. Most LHDs establish billing programs to include all of the clinical services that they provide. Once a health department has established a billing infrastructure, it can seek revenue across programs for reimbursable services such as immunizations.

Ultimately, state or local health departments should decide to bill after carefully assessing the communities they serve. For example, LHDs within the states that have declined Medicaid expansion and that serve predominately uninsured communities may not find revenue generation feasible. If billing is the right decision for the LHD, dwindling public funds could be used for the most vulnerable populations.

Although a majority of health departments have a long history of working with public insurance providers (e.g., Medicaid, Medicare, Children’s Health Insurance Program), many have found the transition to working with private insurers difficult. Despite challenges, LHDs have remained persistent and have developed creative ways to establish successful billing programs.

Billing for immunization of insured individuals makes sense as a way to save money for federal, state, and local governments, assure proper stewardship of public funds and promote public and private payer participation. LHDs play an important role in achieving immunization objectives. The costs of immunizing children and adults can place a burden on the scarce resources of public health departments, unless a proper billing program is in place.

Many of the children and adults seen by LHDs either already have insurance or are potentially eligible for insurance coverage for immunization services. Public programs including Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP), as well as Vaccines For Children (VFC), fund immunizations for individuals with limited financial means. The 2010 Patient Protection and Affordable Care Act (PPACA) is expected to further increase the proportion of the population with insurance coverage for immunizations by increasing the number of insured individuals and requiring coverage of preventive services, including immunization, for both adults and children.

Finally, there are a number of laws and program requirements that require LHDs to bill for services. LHDs provide services and receive funding through public programs. Compliance with the various program requirements, requires LHDs to bill as appropriate. There are many factors that determine the ability of LHDs to bill for immunizations services: local delivery and billing practices for a range of public health services, immunization service volume, and the public and commercial insurance markets.

This paper provides an overview for Illinois public health immunization billing including billing Medicare, Medicaid, and private insurance; but these activities do not exist in isolation. They fit into a bigger picture of planning, budget and policy development, organizational objectives, grants, programs, and community priorities. Billing allows health departments to identify and
tap into existing sources of revenue to survive, even thrive, through tough economic times when people often need care most.
**Immunization Billing Basics**

Understanding the business processes for the services the local health department provides is the beginning step. Each local health department must thoroughly understand the steps involved in providing a service—from checking a client into the clinic, to delivering the service, to billing claims, and paying staff.

**Regulations/Acts Affecting Immunization**

Please note the following regulations affecting immunizations for the State of Illinois:

**Immunization Code (Repealer)**  
(77 Ill. Adm. Code 695)

- **Date Published:** March 4, 2016
- **Illinois Register Citation:** 40 Ill. Reg.
- **Comment Period Expires:** April 18, 2016

The Immunization Code is being repealed and its provisions added to the Child Health Examination Code (77 Ill. Adm. Code 665) to create one comprehensive regulation covering child and student health examinations and immunizations. Currently, immunizations are covered in both the Immunization Code and the Child Health Exam Code resulting in redundant regulations. The repeal of the Immunization Code will remove the redundancy and create a central location for parents and health care providers to find the examination and immunization requirements.

**College Immunization Code**  
(77 Ill. Adm. Code 694)

- **Date Published:** March 4, 2016
- **Illinois Register Citation:** 40 Ill. Reg.
- **Comment Period Expires:** April 18, 2016

This rulemaking proposes changes to the vaccination requirements for incoming college students at Illinois higher education institutions. Specifically, the rulemakings seeks to add a vaccination requirement for meningococcal disease (one dose of meningococcal vaccine on or after 16th birthday) and for pertussis (students must have received at least one dose of Tdap within previous 10 years) and will require college students to show proof of receipt of two doses of rubella, mumps-containing vaccines. The vaccination requirements will take effect beginning with the 2016-17 Fall term. The proposed amendments seek to align Illinois college vaccination requirements with current accepted clinical practices as recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the Academy of Family Physicians (AFP).
This rulemaking proposes changes to the vaccination requirements for children and students. Specifically, the proposed rulemaking revises vaccination intervals allowed for meningococcal vaccination among children in 6th and 12th grades and strengthens polio vaccination requirements for children entering kindergarten in the 2016-17 school year. The proposed vaccination revisions are supported by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP).

This rulemaking also seeks to implement P.A. 99-249 which requires parents and legal guardians seeking a religious exemption for child and student health examinations and immunizations to complete and submit a Certificate of Religious Exemption. This rulemaking provides the formal criteria for use of the Certificate and sets forth the processes by which schools will handle the Certificate.

This rulemaking further seeks to add provisions of the Immunization Code, 77 Ill. Adm. Code 695, which is being repealed. The Child Health Examination Code and the Immunization Code nearly mirror each other. Rather than having two redundant regulations, IDPH is proposing to repeal the Immunization Code and insert its provisions into the Child Health Examination Code to create a one master rule covering child health examination and immunization requirements.

Further specific immunization billing and coverage regulations are described below:

ACIP

The Advisory Committee on Immunization Practices (ACIP) is a Federal Advisory Committee whose role is to provide advice and guidance to the Secretary and the Assistant Secretary for Health and Human Services, and the Director, Centers for Disease Control and Prevention (CDC), regarding the most appropriate selection of vaccines and related agents for control of vaccine-preventable diseases in the civilian population of the United States.

Vaccines For Children (VFC) resolutions passed by the ACIP form the basis for VFC program policies on vaccine availability and use. The National Center for Immunization and Respiratory Diseases (NCIRD) of the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) communicate VFC resolutions to State Immunization and Medicaid programs for dissemination to providers at the local level. Vaccine procured through the VFC program must be administered according to the guidelines outlined by the ACIP in VFC resolutions. (VFC vaccine also may be administered in accordance with State school attendance laws.)
**Medicaid**

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people, including disadvantaged children. Each State Medicaid program must file a Medicaid State plan amendment covering its Pediatric Immunization Program in order to receive Federal funds to operate its Medicaid program and to receive vaccines from the VFC program.

**Medicare**

All Medicare providers are required to file claims on behalf of the client per §1848(g)(4)(A) of the Social Security Act. Medicare Part B pays for pneumococcal vaccines, influenza virus vaccines, and their administration without coinsurance or deductibles. It is inappropriate to require a client to pay for the vaccination up front and to file their own claim for reimbursement.

Medicare Part B does not cover other immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulinum antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as polio, diphtheria, etc., is not covered under Medicare Part B. These vaccines and other commercially-available vaccines (such as herpes zoster) are typically covered by Medicare Part D drug plans when medically necessary to prevent illness. Billing for Part D vaccines goes directly to the third-party drug plan.

**PPACA**

Effective in 2010 with the passage of Patient Protection and Affordable Care Act (PPACA), immunizations are covered under preventive services in most instances.

**PPACA Title I, Sec. 1001 — Coverage of preventive health services in private health plans**

Insurance companies must cover preventive services recommended by the US Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunizations Practices (ACIP); and **health plans cannot impose any cost-sharing requirements**. This includes those vaccines found in the recommended immunization schedule for children, adolescents, and adults. This provision **does not apply to grandfathered plans**—which could include a majority of the existing plans. The common understanding of a grandfathered plan is an individual or group health plan providing coverage on March 23, 2010—the day the bill was enacted.

**PPACA Title I, Sec. 1001 — Extension of dependent coverage in private health plans** - Requires health plans that offer dependent coverage to make it available for an adult child until that child turns 26 years old, with the exception of grandfathered plans. Adult vaccines such as
Meningococcal and Human Papillomavirus (HPV) may also be covered depending on the Department of Health and Human Services clarifying rules.

**PPACA Title I, Sec. 2001 and 4106 — Medicaid** - There are newly eligible persons for the Medicaid program, based on income, gender and family position. These changes will lead to more people receiving Medicaid benefits and potentially more people eligible for Medicaid-covered immunizations. One specific Medicaid section clarifies that the preventive services that could be offered to Medicaid eligible adults includes those services recommended by the USPSTF and those immunizations recommended by the ACIP. The impact will vary by state based on their current Medicaid eligibility and future required expansion.

**Billing Information Needed**

It is expected local health departments (LHDs) perform certain functions related to third-party billing. Health departments with low vaccine volume and no other potential third-party billing may implement these practices and choose not to implement any other billing activities. The basic requirements are detailed below and ensure that compliance with state and federal programs such as the General Public Health Work Program, the Vaccines for Children program and public third-party payer requirements is maintained.

1. **Collect insurance information:** When a patient schedules an appointment or walks in for an appointment, all LHDs should ask the patient or guardian for any third-party coverage information. LHDs need third-party payer information collected at every encounter to determine a child’s eligibility for VFC and provide patients with the necessary documentation to pursue reimbursement of their out of pocket medical expense. It is expected that LHDs will use the billing data repository function to assist in this if they do not have another information system with third-party payer information collection capacity.

2. **Determine Payer Mix:** All LHDs should compile insurance information and determine their payer mix for immunization services, identifying the major potential sources for reimbursement. LHDs can use this information to determine the most cost effective billing approach. This information also indicates which managed care contracts to pursue.

3. **Establish and Implement an Out of Pocket Patient Fee Process:** In accordance with Public Health Law Articles, LHDs must bill patients for vaccines and administration fees as appropriate. LHDs should have approved fees and sliding fee scales.

4. **Encourage Insurance Enrollment:** LHDs should utilize local facilitated enrollment counselors to promote access to care among those patients eligible for public programs.

5. **Submit Claims to Public Insurance Programs:** All public health clinics must claim reimbursement for the services they provide for publicly insured individuals. All LHD clinics must be enrolled as Medicaid and Medicare providers and should verify eligibility and conditions of coverage including enrollment in managed care for the date immunization services are provided.
Billing Information Lifecycle

The revenue cycle and foundational aspects of successful billing practice include information systems, relationships with third-party payers, and personnel resources. The elements for successful immunization billing practice are summarized in the following section.

The revenue cycle is comprised of the financial processes associated with each patient visit, from registration to billing, receipt of reimbursement, and closing each fee balance. The processes are categorized into three parts: front end processes, intermediate processes and back end processes.

**Front End Processes** include scheduling, patient registration, VFC eligibility determination, insurance determination and verification, collection of co-pays, deductibles or self-pay amounts and sliding fee application. The information gathered at this stage of the process is critical to ensure that insurance claims are not denied for reasons such as invalid insurance coverage, service authorization not obtained or service not covered under the member's benefit plan.

**Intermediate Processes** include the capture of service information in an electronic or manual encounter form. This includes procedure and diagnosis codes as well as other data elements required for billing third-party payers and data entry. Correct coding is important for submission of accurate reimbursement claims.

**Back End Processes** consist of claims creation and submission, posting payments to open accounts, claims follow-up and patient billing statements. In addition, back-end processes include those steps in account reconciliation and closure of each fee balance.
Providers need internal reporting tools and control mechanisms in place to ensure all claims are properly adjudicated and routine reports are created to monitor billing processes and outcomes. The **foundation** of successful billing includes three components:

1. **Information System Capacity:** LHDs need an information system or service that can provide:
   - Single-point patient data entry
   - Useful for multiple clinical service areas within a LHD
   - Efficient data transmission
   - Electronic claim submission
   - Availability of service data for billing functions
   - Account reconciliation
   - Financial and statistical reporting capabilities
   - Data import and export capabilities

2. **Third-party relationships:** To obtain reimbursement for immunizations provided to enrolled patients, LHDs need to develop relationships with insurance plans, including:
   - Network agreements with insurance plans
   - Credentialing of LHD practitioners with insurance plans so that LHDs can be reimbursed as network providers
   - Clearinghouse Agreements to enable streamlined LHD communication with payers. These services may be free or require contract agreements.

3. **Workforce Capacity and Capability:** LHDs need sufficient personnel resources to:
   - Handle scheduling and registration
   - Submit claims, post payments and address outstanding accounts
   - Handle electronic claims, enrollment process and submit paperwork for electronic funds transfer (EFT) deposits from payers
   - Manage the health plan contracting and credentialing effort
   - Handle IT support for software implementation, maintenance and troubleshooting

**Billing Policies and Procedures**

It is important for LHDs to develop policies and procedures relating to the revenue cycle, billing process, and billing requirements. Written policies and procedures are vital to the success of billing and should be carefully developed to include all aspects of the process. Billing staff should be well trained on the policies and procedures and have the ability to refer to them at any time to aid in performing their assigned tasks. The policies and procedures should be kept up-to-date at all times. The LHDs should update the policies and procedures immediately when any changes to the processed and systems occur.
Coding and Billing for Immunization Services

The vaccine-related component included in every preventive medicine visit is the review of the vaccine history. This comprises collecting information on vaccines and vaccine preventable diseases that the patient has encountered and then comparing it to the Department of Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC) “Recommended Immunization Schedule”. Doing so then allows the provider to determine which vaccines are required or recommended as part of the preventive medicine services (PMS) medical decision making process.

Just as the history and physical examination yield a “well child” diagnosis, so does the patient’s general vaccine history yield a recommendation of “required vaccines.” The PMS component related to vaccines ends at this point. All vaccine counseling services beyond the general vaccine history are included in the immunization administration (IA) codes (90460-90474).

This includes, but is not limited to:

- Obtaining information on potential contraindications to receiving a particular vaccine(s)
- Reviewing/discussing the relevant CDC Vaccine Information Statement(s) (VIS)
- Reviewing/discussing risks and benefits of specific vaccine(s)
- Obtaining informed consent for each vaccine(s) administered
- Addressing all other patient/parent concerns and questions related to vaccines and immunization administration

For this reason, when vaccines are given at the time of a preventive medicine service, the IA code(s) must be separately reported from the PMS code so that the provider can be appropriately paid for the work involved in vaccine counseling.

The Immunization administration codes specify that the counseling must be performed by a physician or “other qualified health care professional (OQHCP).” A "physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.
To report CPT codes 90460–90461, the physician or the qualified health care professional who is reporting the service must perform face-to-face counseling (and so document that the counseling was personally performed).

**Vaccines Administered at Well-child Visits**

When vaccines are provided as part of a well-child encounter, the ICD-10 guidelines instruct that code Z00.121 and Z00129 (routine health check for child over 298 days old) includes immunizations appropriate to the patient's age. Code Z23 may be used as a secondary code if the vaccine is given as part of a preventive health care service, such as a well-child visit.

**ICD-10 for Combination Vaccines**

ICD-10 requires only one code (Z23) per vaccination, regardless if single or combination. LHDs should report Z23 for vaccination diagnoses.

**Evaluation and Management Services Provided on the Same Date as Vaccine Administration**

When an evaluation and management service (other than a preventive medicine service) is provided on the same date as a prophylactic immunization, **Modifier -25** may be appended to the code for the evaluation and management service to indicate that this service was significant and separately identifiable from the physician's work of the vaccine counseling/administration.

**Example:** A patient presents for a visit to evaluate the control of his/her diabetes and at the same visit receives an influenza vaccine administration. A physician might report code 99213-25 with diagnosis code E11.9 in addition to the appropriate flu vaccine and administration codes.

**Adding National Drug Codes (NDC) to Claims**

Medicaid plans and private payers may require the inclusion of a vaccine product's National Drug Code (NDC) on the claim line for each vaccine product. This can be a bit confusing if the product is labeled with a 10-digit NDC, as HIPAA requires that NDC have 11-digits. To correctly report the NDC in the HIPAA format, LHDs may have to translate the NDC.

The common format for submitting an NDC is a number that, if hyphenated, would appear in a 5-4-2 format. Some drug products are labeled in 4-4-2, 5-3-2, or 5-4-1 formats. To change these codes to the 11-digit format, a zero is placed within the product code to create the 5-4-2 format.
Here are some examples showing addition of a zero to create this format:

<table>
<thead>
<tr>
<th>10-DIGIT NDC</th>
<th>11-DIGIT NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>4444-4444-22</td>
<td>04444-4444-22</td>
</tr>
<tr>
<td>55555-333-22</td>
<td>55555-0333-22</td>
</tr>
<tr>
<td>55555-4444-1</td>
<td>55555-4444-01</td>
</tr>
</tbody>
</table>

This information is not required by all payers.

**Reporting Administration per Component**

The pediatric immunization administration codes are:

- 90460: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
- +90461: Each additional vaccine/toxoid component (list separately in addition to code for primary procedure)

These codes are reported per vaccine/toxoid component. CPT defines a component for these purposes as each antigen in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components.

LHDs may report multiple units of code 90460 for each first vaccine/toxoid component administered. No modifier should be required when reporting multiple first components. Note also that code 90460 does not apply only to combination vaccines, but also to single component vaccines (such as influenza, human papillomavirus, or pneumococcal conjugate vaccines). This base code is reported for each vaccine administration to patients 18 years of age and under who receive counseling about the vaccine from a physician or qualified health care professional at the time of administration. Code 90461 is an add-on code reported for each additional vaccine component administered.

Report codes 90471-90474 for immunization administration of any vaccine that is not accompanied by face-to-face physician or other qualified health care professional counseling the patient and/or family, or for patients over 18 years of age.
Notes About Codes 90460 and 90461

To correctly report vaccine counseling and administration with these codes, it is important to recognize what the codes do and do not include.

- These codes are limited to immunization administration, meaning purchased vaccine products must be separately reported.
- A face-to-face service where a physician or other qualified health care professional (qualified per state licensure) provides counseling to the patient and/or caregivers is required to report 90460-90461.
- In the absence of counseling, the administrations must be reported with codes 90471-90474.
- 90460-90461 are reported for administration to patients 18 years of age and under.
- Code 90460 is reported for each separate administration of single component vaccines and/or first component of a combination vaccine.
- When reporting administration of combination vaccines, code 90460 is reported for the first component and add-on code 90461 is reported for each additional component (no modifier -51 required).
- Note that route of administration (whether injection, oral, or intranasal) does not matter, since the codes include “via any route of administration.”

Administration Coding Example

An 11-year old girl presents for a preventive visit (99393). In addition, the child and her mother are counseled by the physician on risks and benefits of HPV (90649), Tdap (90715) and seasonal influenza (90660) vaccines. The mother signs consent to administration of these vaccines. A nurse prepares and administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction.

CPT Codes reported are:
99393 - Preventive service
90649 - HPV vaccine
90460 - Administration first component (1 unit)
90715 - Tdap vaccine
90460 - Administration first component (1 unit)
90461 - 2 additional components (2 units)
90660 - Influenza vaccine, live, for intranasal use
90460 - Administration first component (1 unit)
Vaccine Coverage for Medicare Part B

Medicare Part B provides preventive coverage only for certain vaccines. These include:

- Influenza: once per flu season (codes 90653-90657, 90660-90662, 90672-90673, 90685-90688, Q2034-Q2039)
- Pneumococcal: (codes 90670, 90732, once per lifetime with high-risk booster after 5 years)
- Hepatitis B: for persons at intermediate- to high-risk (codes 90739- 90740, 90743-90744, 90746-90747)

Administration services for these preventive vaccines are reported to Medicare using HCPCS codes as follows:

- G0008 administration of influenza virus vaccine
- G0009 administration of pneumococcal vaccine
- G0010 administration of Hepatitis B vaccine

The diagnosis codes to report with these preventive vaccines are:

- V04.81 when influenza vaccine is administered but pneumococcal is not
- V06.6 when both the influenza and pneumococcal vaccines are administered
- V03.82 when administering pneumococcal vaccine but not the influenza vaccine
- V05.3 when administering the hepatitis B vaccine

Other immunizations are covered under Medicare Part B only if they are directly related to the treatment of an injury or direct exposure (such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulinum antitoxin, antivenin, or immune globulin).

Coverage of other vaccines provided as a preventive service may be covered under a patient's Part D coverage.

Billing Considerations for Part B Vaccines

Whether participating or non-participating in Medicare, physicians must accept assignment of the Medicare vaccine payment rate and may not collect payment from the beneficiary for the vaccine. Non-participating physicians may choose not to accept assignment on the administration fee. When a non-participating physician or supplier provides the services, the beneficiary is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows for the administration fee. The limiting charge provision does not apply to the influenza benefit.

The influenza and pneumococcal vaccines and the administration of these vaccines are not subject to the Medicare Part B deductible or co-insurance. Medicare pays at 100% of the
allowable amounts. However, the Hepatitis B vaccine and administration are subject to the deductible and co-insurance. Medicare pays at 80% after the patient has met their Part B deductible.

Medicare will pay two administration fees if a beneficiary receives both the influenza virus and the pneumococcal vaccine on the same day.

G Codes are used to designate the administration of a vaccine. For example, when billing for influenza virus vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the CMS-1500 claim form. When billing for the influenza virus vaccine only, billers should list only HCPCS code 90658 in block 24D of the CMS-1500 form. The same applies for pneumococcal and hepatitis B billing using pneumococcal and hepatitis B HCPCS codes. When a vaccine and the administration of the vaccine are furnished by two different entities, the entities should submit separate claims.

Q Codes are used to designate multi-dose flu vaccines. Providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered, even where the vaccine involves multiple doses.

Claims for the hepatitis B vaccine must include the name and NPI of the ordering physician, as Medicare requires that the hepatitis B vaccine be administered under a physician’s order with supervision. This is not necessary for the influenza and pneumococcal vaccines for which Medicare does not require a physician’s order or supervision. (Note that state law may require an order and/or supervision.)

**Vaccine Coverage for Medicare Part D**

Payment for Part D covered vaccines and their administration are made solely by the participating prescription drug plan. This includes all preventive vaccines not covered under Medicare Part B.

When providing a Part D covered vaccine to a Medicare patient, the physician should charge the patient for the vaccine and its administration. To facilitate the patient's reimbursement by his or her Part D plan, the physician's office should complete a CMS-1500 claim form for the vaccine and administration service and give it to the patient to file as an unassigned, out-of-network claim. Some patients may also request a prescription for preventive vaccines and their administration to meet their Part D plan requirements to have this prescription filled by contracted providers (pharmacy and injection clinic).

Furthermore, an Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is a standardized notice that the LHD designee must give to a Medicare beneficiary before providing certain items or services, including Medicare Part B (outpatient) services. The ABN must be issued when the health care provider believes that Medicare may not pay for an item or service that Medicare usually covers because it is not considered medically reasonable and
necessary for this patient in this particular instance. ABNs are only provided to beneficiaries enrolled in Original (Fee-For-Service) Medicare.

The ABN allows the patient to make an informed decision about whether to receive services and accept financial responsibility for those services if Medicare does not pay. The ABN serves as proof that the beneficiary had knowledge prior to receiving the service that Medicare might not pay. If the LHD does not deliver a valid ABN to the beneficiary when required by statute, the patient cannot be billed for the service and the provider may be held financially liable.

The ABN also serves as an optional notice that LHDs may use to forewarn beneficiaries of their financial liability prior to providing care that Medicare does not cover. The GA modifier indicates that a waiver of liability statement is on file with the LHD. The GA modifier should be used with the ABN on Form CMS-1500 when the claim is billed to Medicare.

**Provider Enrollment & Credentialing**

Before a health department can begin to bill and receive reimbursement from either a public or private insurance payer for immunization (or other) services, the health department’s medical staff must be credentialed as participating providers based on the payer’s accepted standards or an accepted standard within the state. Healthcare credentialing is “the process of verifying education, training, and proven skills of healthcare practitioners.” All healthcare providers must be evaluated through a credentialing process in order to successfully bill third-party payers, with limited exception. The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that the “Health Care Professional Credentialing and Business Data Gathering Form” be completed per provider.

**Eligibility & Verification**

Before rendering service(s) to a patient, LHDs will need to determine what program and/or insurance coverage will reimburse for the vaccine and/or the administration. There are two verifications to be addressed:

**Eligibility**
- Is the patient eligible for the program/health plan for the date of service?
- Is the patient eligible under more than one program/health plan?
- Is your LHD considered a participating provider for this program/health plan?

**Coverage**
- What is the coverage, or benefits, that will be provided by the program/health plan?
- Are all preventive immunizations covered under the medical portion of a program/health plan, or are some covered under a separate drug plan?
- Will a deductible, copayment or coinsurance be applied to the immunization?

Frontline staff should brief clients on the intake process prior to receiving services. An effective intake process begins with a registration form that gathers vital information on the client’s demographics, insurance coverage, and services requested. New patients should complete a
form at their first visit. Established patients should complete one if they have any changes in their information since their last visit. Verifying and updating this information is critical at every visit.

Important steps that should be taken with every client at every visit:

- Copy the client’s primary and any secondary insurance cards
- Verify eligibility, policy status, effective date, type of plan and Exclusions
- Inform client of their responsibility for co-pays, coinsurances and deductibles
- Inform client of Waiver for non-covered services and payment options

It is the provider’s responsibility to verify coverage before services are rendered. Failure to do so may result in non-payment of non-covered services and difficulties recouping payment from the patient after services have been provided. “Active” coverage does not guarantee reimbursement for services listed on the Fee Schedule. Please refer to the client’s individual insurance plan/exclusions to identify “Non-Covered” services.

In order to charge clients for non-covered services, a Waiver for Non-Covered Services with the following information must be provided to the patient:

- Identify the service that is not covered
- Identify covered service that may be available in lieu of the non-covered service
- The cost of the service and payment arrangements
- The client must sign the Waiver indicating acceptance of the non-covered service and agreement to pay for the non-covered service

As the result of state and federal laws, most plans cover immunizations that are ACIP recommended. However, whether or not they are covered without any cost-sharing can be confusing due to exceptions in those same laws. Especially be aware of the grandfathered plans because:

- Immunizations can be subject to deductibles and copay/coinsurance amounts
- There is no way to know if cost-sharing applies because the ID card isn’t required to display the plan’s grandfathered status

**Coordination of Benefits**

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

By federal law, Medicaid is the “payer of last resort” in most circumstances. Coordination of Benefits (COB) is the process of determining the primary payer. A third-party resource is an individual, entity, or program that is or may be liable to pay for all or part of the expenses for
medical care provided to a Medicaid client. COB regulations require that all health plans coordinate benefits to eliminate duplication of payment and ensure clients receive the maximum benefits they are entitled to. Medicaid will consider payment of a claim only after all other third-party resources have been exhausted.

When a client has other coverage that is potentially liable for payment of a claim, a COB claim is required prior to billing Medicaid. A COB claim submitted to Medicaid may be processed in one of two ways:

- **Cost-avoid**: A Provider must bill the primary payer before billing Medicaid. Medicaid will pay the claim once the primary payer processing information is included on the claim.
- **Pay-and-chase**: Medicaid will pay for the services and then attempt to recover from the liable third-party. If Medicaid pays for these services, the Provider cannot bill the third-party payer.

When the liability of a third-party cannot be established or is not available to pay for the client's services within an applicable timeframe, Medicaid may reimburse the provider for covered services in accordance with standard reimbursement procedures.

**Third-Party Liability Non-covered List (Blanket Denial)**

When a service is not covered by a beneficiary’s primary insurance plan, a blanket denial letter can be requested from the insurance carrier. The insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. Providers could retain this statement on file to be used as proof of denial for one year. The non-covered status must be reconfirmed and a new letter obtained at the end of one year.

A Medicare crossover claim is any claim that is approved by Medicare and then sent to Medicaid for consideration of payment not to exceed the sum of the Medicare deductible, copay, or coinsurance. The claim must be approved by Medicare in order to be considered a crossover claim. “Approved” does not mean paid; sometimes the charges approved by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare. It is important to remember that claims that are denied by Medicare are not crossover claims. If a member is a Qualified Medicare Beneficiary (QMB) and Medicare denies the claim, do not bill Medicaid.

The receipt of a crossover claim by Medicaid does not mean that Medicaid will make a payment on the claim. If Medicaid approves the claim, a payment of the sum of the coinsurance and deductible may be made. If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay anything on the claim, but the claim will still be a paid Medicaid claim.
The following suggestions may assist providers in reducing payment delays attributed to COB-related problems:

- Ask patients about secondary insurance coverage. Collect and confirm primary and secondary insurance information at each visit.
- Know what plans and payers need to pay claims. Nearly all plans require a copy of the Explanation of Benefits (EOB) from the primary payer prior to paying a claim as the secondary payer. Most plans and payers publish their requirements and the information should be available in provider manuals, online, and by contacting physician/provider representatives.
- Primary & Secondary Payers: The following rules are used to determine the primary and secondary payer:
  - The payer covering the patient as a subscriber will be the primary payer.
  - If the patient is a dependent child, the payer whose subscriber has the earlier birthday in the calendar year will be the primary payer. This is known as the Birthday Rule.

### Contracting with Payers

In order to bill most payers, the LHD must be contracted with the payer. It is best to contact each payer and ask how claims will be processed with and without a contract. Also an LHD may contract with a network. This allows the LHD to bill multiple payers under one contract. One way to facilitate billing by public health departments is to require insurance companies to treat such clinics as in-network providers.

Similarly, “any willing provider” laws provide a unique opportunity for states to integrate service providers into the existing third-party reimbursement system. “Any willing provider laws require that insurers, managed care organizations, and other health plans give all physicians (and sometimes other providers) membership on their preferred provider lists if those physicians are willing to meet the terms and conditions for membership and if they offer the type of medical services that the insurers or managed care organizations offer their subscribers.

To be considered as an in-network provider, health departments identified as a “facility” must enter into a contractual agreement with third-party payers to provide a limited range of services to covered members. The Provider Agreement also includes specific guidance on the responsibilities, reimbursement rates and claim submission processes that both parties must adhere to.

### Claims Submission & Resubmission

**Claim Forms/Electronic Billing**

The billing process requires the completion of various electronic forms or paper documents. Many billing models allow for the documentation to be created and stored in an electronic format. The terms superbill, charge ticket and encounter forms are generally interchangeable. This is the document used to record the services being provided to clients. Typically, it is a log sheet where the health care provider checks a series of boxes to indicate the services provided to the patient and an explanation of why these services were provided. If the LHD is using an
electronic health record (EHR) system, the superbill document will be located on the computer and will be completed by the health care provider on the computer. Without an EHR, the same tasks are accomplished manually and then the data is manually entered into the billing model by the billing staff. Please see Addendum B for a sample superbill.

When health departments bill third-party payers, they typically require accurate completion of a claim form that provides information about the patient’s demographics, services provided, and type of provider responsible for the services (e.g., physician, nurse, or therapist). The claim form conveys this information as diagnostic codes and procedure codes. Third-party payers rely on the existing system of diagnosis and procedure codes to administratively and financially reimburse for services. Proper use of the diagnosis and procedural codes, as well as accurate coding, is essential for claims submitted to third-party payers.

The Health Insurance Portability and Accountability Act (HIPAA) requires health care providers to obtain a National Provider Identifier (NPI) for use in standard HIPAA transactions including insurance billing. Providers obtain a NPI from the Centers for Medicare and Medicaid Services (CMS). The NPI number never expires and will not change as the result of job or relocation. It is intended as a unique identifier for all health plans to utilize. NPI numbers are essential to most insurance enrollment and billing processes.

The healthcare services coding system is regulated by the Centers for Medicare and Medicaid Services and is recognized under the Health Insurance Portability and Accountability Act. The Current Procedural Terminology (CPT) coding system is maintained and copyrighted by the American Medical Association and revised each year in October. The CPT codes describe the medical, surgical, and diagnostic services provided. Codes identify the immunization and other services provided by the LHD on claim forms and other billing materials. Vaccines, administration, and office visits are reported using separate codes.

The submission and resubmission of claims focuses on the importance of converting clinical services provided to a client into billable claims and submitting them via an Electronic Data Interchange (EDI) to third-party payers for reimbursement. To receive proper payment for services, public health billing staff must collect accurate information required to submit a CMS 1500 insurance form correctly.

The CMS-1500 form is the standard for submitting health insurance claims on paper to private insurers, Medicare and Medicaid. Instructions on completing the form can be found online with various insurance carriers and the Centers for Medicare & Medicaid Services (CMS). Photocopies of the CMS-1500 form cannot be used for submission of claims, since copies may not accurately replicate the scale and OCR color of the form.

After the insurance carrier receives and processes a completed CMS-1500 form, it sends the LHD a status report called an Explanation of Benefits (EOB). There is no standard format for how insurance companies report payment information on their EOBS. EOBS typically include a
listing of the services provided, the amount billed, any insurance payments and the amount due from the patient. The EOB is sometimes accompanied by an insurance benefits check.

Medicare supplies a similar report, the Explanation of Medicare Benefits (EOMB), and Medicaid sends Remittance Advices (RAs, also called 835s). These forms all accomplish the same purpose—to explain the status of a claim. More specifically, an EOB, EOMB or RA is likely to include:

**Negotiated or Allowed Amount:**
The in-network rate that was negotiated for the service. Otherwise this will be the recognized amount under the member’s plan.

**Paid Amount:**
The actual amount paid by the insurer for the item or service, after coinsurance and deductibles are factored in.

**Copay Amount:**
Identifies the amount the patient owes as a copayment for this service.

**Deductible Amount:**
This is the amount of the patient deductible that applies to the “submitted charges” or the “negotiated or allowed amount.”

**Pending or Not Payable:**
Portions of the claim amount may be pending or is denied.

**See Remarks or Message Codes:**
These explain the reason(s) that an amount is pended or denied.

Unfortunately, some number of the “remarks” or “message codes” received may likely indicate denial of payment. Denials occur for many reasons. Some denied claims will ultimately be paid if they are rebilled. Others will not. Some common reasons LHDs are denied payment are:

- no coverage on date of service
- not a contracted provider
- not a covered service
- coding errors
- applied to deductible

A denial doesn’t necessarily translate into a write off. The key is to understand the reason for the denial, and to correct and resubmit the claim as appropriate. Once the LHD becomes accustomed to filing claims, interpreting denial codes may not be that difficult and will generally know what to expect of each insurance company. If an LHD receives a denial from a contracted carrier, follow up is necessary.

As more and more importance is put on electronically submitting claims due to other Federal initiatives, many electronic billing processes evolved to utilize a clearinghouse. Rather than submitting claims to each payer separately—including private insurance, Medicare and Medicaid—the LHD can transmit all claims to the clearinghouse which checks them for errors and efficiently and securely transmits them to the appropriate carrier for payment.
Claim Requirements

Providers must take all reasonable measures to determine a third-party payer’s liability for covered services prior to filing a Medicaid claim. If a third-party insurance plan denies or pays part of the applicable reimbursement rate:

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.
- When a carrier issues a blanket denial letter for a non-covered procedure code, the provider should include a copy of the denial.

For MCOs, failure to file a claim within the contracted timely filing after a service is rendered and/or failure to obtain a required prior approval or precertification will result in a denial of that claim. Obtaining prior approval or precertification does not guarantee payment of a claim. If a provider believes a negative adjustment is appropriate, the provider may adjust and resubmit a claim.

A third-party payer may deny part or all of a claim for the following reasons: 1) The services are not covered; 2) The client was not eligible on the date of service; 3) The provider failed to obtain prior approval or precertification for the required services; or, 4) The services provided have been determined to be medically unnecessary.

Mass Immunizers

Individuals and entities interested only in delivering vaccinations must enroll as a Medicare provider. If they are interested in becoming "mass immunizers," which are allowed to provide flu and/or pneumococcal vaccinations to a large number of beneficiaries, they must also enroll and follow the special instructions for mass immunizers. Mass immunizers, also known as community vaccinators, often provide influenza and pneumococcal vaccinations in non-traditional settings, such as churches and grocery stores. Existing providers and suppliers that wish to provide mass immunization services must also obtain a provider specialty number to become mass immunizers. Instructions for enrolling as a traditional Medicare provider or supplier, or as a mass immunizer are contained in the links below.

Mass immunizers have two options for how they bill:

1) Roster billing allows mass immunizers to complete one 1500 or 1450 paper form with the type of vaccination (influenza or pneumococcal) and attach a roster listing the beneficiaries
who received that type of vaccination, rather than submitting separate 1500 or 1450 paper claim forms for each individual.

2) Centralized billing allows mass immunizers to submit influenza and pneumococcal vaccination claims to a single carrier for processing regardless of the geographic locality in which the vaccination was delivered. Centralized billing is available for mass immunizers that serve beneficiaries in three or more states.

**Filing Time Limits**

Every health insurance company has its own policy on timely filing. Visit each payer site or contact a representative for details and updated information. Know time limitations for filing claims. Time limits can vary with the company. Private health insurance companies set their own time limits for filing. When contracting with health plans, LHDs may want to negotiate billing time limitations so they fit well with the LHD’s business schedule.

**Appeals Process**

Every health insurance company has a grievance and appeal procedure defined in its policy. LHDs can appeal a third-party payer’s decision to deny a claim or pay less than the amount billed. Please refer to the appropriate payer’s website for instructions on to appeal a claim. The third-party payer may still deny a claim based on medical necessity despite pre-approval and a correctly coded claim. Appeal requests that do not contain sufficient information will not be processed.

**Medicaid Denial Issues**

When facing denials, there are multiple reasons that could be causing the issue. The first step in dealing with a denial is to review the denial code and determine what is causing the denial. Review prior claims or reach out for assistance from other billers.

**VFC & VFA Programs**

**Eligibility, Provider Enrollment, and Billing**

**Vaccines For Children (VFC)**

Most public health departments participate in the Vaccines For Children (VFC) program, a federal program that provides vaccines at no charge to eligible children less than 19 years of age. In Illinois, the VFC program also currently provides vaccines to CHIP or AllKids enrolled children less than 19 years of age. With each dose of VFC vaccine administered, VFC providers are required to report patient immunization information, including patient eligibility information. While there is no cost in acquiring the VFC-supplied vaccine, the costs of administering the VFC-supplied vaccine can be charged to the patient’s insurance. Vaccine administration costs can be requested of un-insured and under-insured patients; although those patients cannot be turned away for their inability to pay. VFC providers may charge VFC-eligible children not covered by Medicaid a vaccine administration fee per dose (not per
antigen) of vaccine. VFC providers may not exceed the federal maximum administration fee nor may they charge non-Medicaid VFC-eligible children for the cost of the vaccine.

LHDs must purchase their own supplies of vaccine for administration to children who are not eligible to receive this Federal or State supplied vaccine. The Illinois Department of Public Health (IDPH) has collaborated with the U.S. Centers for Disease Control and Prevention (CDC) to provide pediatric vaccines through the Vaccines for Children (VFC) program. Childhood vaccines have become more expensive and immunization services more complex as additional vaccines have been recommended by the Advisory Committee on Immunization Practices (ACIP).

Annual enrollment for the VFC program must be completed by participating providers in the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). The enrollment agreement, along with other required documents for enrollment must be signed by the provider’s medical director and faxed or e-mailed to IDPH.

VFC providers are required to register to use I-CARE, a tool used by health care providers, parents, public health agencies, and schools to record immunization records. The VFC program utilizes the I-CARE system to record VFC vaccine use, inventory, and ordering completed online.

• If you have not registered for I-CARE, complete the I-CARE application as soon as possible so you may complete the VFC enrollment. Information and forms for enrollment in I-CARE are available at: http://www.dph.illinois.gov/topics-services/prevention-wellness/immunization/icare .

• If you have already enrolled in I-CARE, but do not have access yet, contact the I-CARE team at dph.ICARE@illinois.gov to check the status of your I-CARE enrollment.

If you are not interested in continuing in the VFC program, complete the VFC Provider Withdraw Form, which is available in I-CARE on the home page under “Immunization Links.”

Persons on the Medicaid “List of Excluded Individuals/Entities” are excluded from participating in federally-funded health care programs, and are not eligible to participate in the VFC program. The Illinois VFC program will exclude providers from participating in the VFC program if the provider is found to be in non-payment status under Medicare, Medicaid, and other Federal health care programs. Exclusion of providers also may occur due to Office of Inspector General (OIG) sanction, failure to renew license or certification registration, revocation of professional license or certification, or termination by the state Medicaid agency.

The Illinois Immunization Program and Medicaid monitor provider exclusions identified by the Office of the Inspector General (OIG). This List of Excluded Individuals and Entities on the OIG website can be viewed at http://oig.hhs.gov/fraud/exclusions/index.asp. This list is checked monthly against currently enrolled providers. Claims are not processed by Medicaid for providers on the OIG list. Providers are strongly encouraged to check the OIG website list of
excluded individuals/entities prior to hiring or contracting with any individuals or entities.
Enrolled providers who employ a person (including, but not limited to, physicians, mid-level practitioners, nurses or nursing aides) from the excluded provider list will be terminated from the program and the state Medicaid and MIG agencies will be notified.

VFC providers must designate a vaccine coordinator and backup vaccine coordinator(s) who will be fully trained to oversee and manage the clinic’s vaccine supply. Contact name and information for each vaccine coordinator must be current in the clinic’s enrollment in I-CARE. Any personnel changes in this role must be immediately reported to the VFC program through the “contact us” link in I-CARE.

Each VFC vaccine coordinator is required to complete and maintain documentation of receiving annual VFC education on vaccine storage and handling. Education is available through VFC compliance site visits; VFC trainings; or through CDC online training, “You Call The Shots – Module 10 – Storage and Handling,” available at http://www.cdc.gov/vaccines/ed/youcalltheshots.htm.
Screening for VFC eligibility must occur with clinic patients 0 to 18 years of age, prior to vaccine administration and must have VFC eligibility screening documented in the patient’s permanent medical record (paper-based or electronic medical record) at each immunization encounter.

Eligibility documentation must be kept in the patient’s medical record for three years.
Documentation of eligibility screening must include the following elements:

- Date of screening
- Whether the patient is VFC eligible or not VFC eligible
- If VFC eligible, the eligibility criteria the patient met

Providers must screen for and document VFC eligibility with every visit. All provider forms are available in I-CARE on the home page under “Immunization Links.”

To be eligible to receive VFC vaccine, children (regardless of their state of residency) must be younger than 19 and meet at least one of the following criteria:

- Medicaid-eligible: a child who is eligible for the Medicaid program. [For the purposes of the VFC program, the terms “Medicaid-eligible” and “Medicaid-enrolled” are equivalent and refer to children who have health insurance covered by Medicaid, including All Kids.]
- Uninsured: a child who has no health insurance coverage.
- American Indian or Alaskan Native (AI/AN): as defined by the Indian Health Care Improvement Act (25 U.S.C. 1603).
- Underinsured: a child who has health insurance, but the coverage does not include vaccines or a child whose insurance covers only selected vaccines. Children who are underinsured for select vaccines are VFC-eligible for non-covered vaccines only.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied.
for payment by the insurance carrier because the plan’s deductible had not been met. Privately insured children, even those without a medical home, cannot be vaccinated with VFC vaccine by any VFC provider site – even an FQHC or RHC. These children must be vaccinated with privately acquired vaccine.

Children who have private health insurance that includes full immunization benefits and Medicaid as a secondary insurance can be VFC-eligible as long as they are enrolled in Medicaid. VFC is an entitlement program, and participation is not mandatory for an eligible child. For children who have full immunization benefits through a primary private insurance, the decision to participate in the VFC program should be made based on what is financially most cost effective to child and his/her family. **Providers should ensure private insurance will cover the vaccinations before vaccines are administered, as the VFC program does not allow the borrowing of VFC vaccines.**

Minors under 19 years of age who do not know their insurance status and who present at family planning clinics for contraceptive services or sexually transmitted disease treatment can be considered uninsured for the purposes of the VFC program. CDC defines a family planning clinic as a clinic or provider whose purpose is to prescribe contraceptives and/or treat sexually transmitted diseases. Any VFC-enrolled provider whose main services are primary or acute care does not meet CDC’s definition of a family planning clinic, cannot use this VFC eligibility category.

LHDs who wish to qualify to vaccinate underinsured children using VFC vaccine must be established and recognized as a FQHC, RHC or an agency with FQHC delegate authority. A FQHC can use a memorandum of understanding (MOU) (request from VFC administrator) to delegate authority to certified LHDs who are not an FQHC with a Health Resources and Services Administration PHS Section 330 grant award notice or an RHC with a Department RHC status letter and participate in the Illinois VFC program to vaccinate underinsured children on their behalf. Providers should retain a copy of their MOU and submit annually during VFC re-enrollment to continue to be able to administer VFC vaccine to underinsured patients.

Please refer to **Addendum A** for further instructions from the Illinois Department of Public Health regarding VFC billing operations for VFC supplied vaccines.

VFC providers have contributed to increased immunization coverage level rates and reduced delays in immunizations and, subsequently, the risk of serious illness or death from vaccine-preventable diseases. To ensure providers enrolled in the VFC program adhere to the many program requirements, increased accountability processes are needed. VFC enrollment visits, compliance site visits, and unannounced storage and handling visits are conducted at all VFC-enrolled provider officers throughout Illinois to ensure accountability and compliance with VFC policies and procedures.
**Vaccines For Adults (VFA)**

Most State Medicaid agencies cover at least some adult immunizations but not all offer vaccines at the ACIP standards. CMS is currently collaborating with other HHS officials on the ACIP to identify gaps in adult immunization activities and to develop recommendations to improve vaccination rates in adults. The Department of Health and Human Services (HHS) is planning a public awareness campaign to improve adult Medicaid enrollees' vaccination rates for influenza and pneumonia.

The Illinois Department of Health Care and Family Services (HFS) pays for medically necessary adult immunizations as determined by the provider. Centers for Disease Control and Prevention (CDC) guidelines should be followed. Adult immunizations are a critical component of preventive and primary care. Common examples of such immunizations are influenza vaccine, pneumococcal vaccine, tetanus and diphtheria toxoids vaccine (Td), tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap). Providers should bill using the appropriate CPT code for the individual service.

**Confidentiality in Billing**

Another public health department concern is billing for confidential services. Most private insurance companies send an explanation of benefits (EOB) to the insured policy holder, which may breach the confidentiality of adolescents or spouses for services such as STI testing and treatment. Public health departments can protect confidentiality by asking clients upfront if they will let the health department bill their private insurance. This small change can ensure that clients were aware of their privacy rights and that EOBs were sent by insurance plans. Those adult clients that do not want the EOB sent could be asked to pay for the services on a sliding scale.
## Appendices

### Acronyms

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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>BCBS</td>
<td>Blue Cross Blue Shield</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>COB</td>
<td>Coordination of Benefits</td>
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<td>COBRA</td>
<td>Consolidate Omnibus Budget Reconciliation Act</td>
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<td>NOS</td>
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<td>UR</td>
<td>Utilization Review</td>
</tr>
</tbody>
</table>
Definitions

**ACA** – Affordable Care Act. Also referred to as “ObamaCare”. A federal law enacted in 2010 intended to increase healthcare coverage and make it more affordable.

**Accept Assignment** – When a provider accepts as “full-payment” the amount paid on a claim by the insurance company, excluding the coinsurance, deductible or co-pay due from the patient.

**Adjusted Claim** – A claim that has been corrected, due to an error during submission or payment, which results in a credit or payment to the provider.

**Allowed Amount** – The reimbursement rate that the insurance company will pay for a procedure.

**AMA** - American Medical Association. The AMA is the largest association of doctors in the United States. They publish the Journal of American Medical Association which is one of the most widely circulated medical journals in the world.

**Aging** - One of the medical billing terms referring to the unpaid insurance claims or patient balances that are due past 30 days. Most medical billing software’s have the ability to generate a separate report for insurance aging and patient aging. These reports typically list balances by 30, 60, 90, and 120 day increments.

**Appeal** - When an insurance plan does not pay for treatment, an appeal (either by the provider or patient) is the process of objecting this decision. The insurer may require documentation when processing an appeal and typically has a formal policy or process established for submitting an appeal. Many times the process and associated forms can be found on the insurance provider’s web site.

**Applied to Deductible** - You typically see these medical billing terms on the patient statement. This is the amount of the charges, determined by the patients insurance plan, the patient owes the provider. Many plans have a maximum annual deductible that once met is then covered by the insurance provider.

**Assignment of Benefits** - Insurance payments that are paid to the doctor or hospital for a patient’s treatment.

**Beneficiary** - Person or persons covered by the health insurance plan.

**Blue Cross Blue Shield (BCBS)** - An organization of affiliated insurance companies, independent of the association (and each other), that offer insurance plans within local regions under one or both of the association’s brands (Blue Cross or Blue Shield). Many local BCBS associations are non-profit BCBS sometimes acts as administrators of Medicare in many states or regions.

**Business Associate** - The HIPAA definition of Business Associate has broad applicability and includes, other than a health care provider’s employees, "partners" that may provide legal, actuarial, accounting, consulting, data aggregation, management, administration or financial services wherein the services require the disclosure of individually identifiable health information.

**Capitation** - A fixed payment paid per patient enrolled over a defined period of time, paid to a health plan or provider. This covers the costs associated with the patients’ health care services. This payment is not affected by the type or number of services provided.

**Carrier** – The insurance company or “carrier” the patient has a contract with to provide health insurance

**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services. Recently renamed
TRICARE. This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors.

**Charity Care/Sliding Scale** - When medical care is provided at no cost or at reduced cost to a patient that cannot afford to pay.

**Clean Claim** - Medical billing term for a complete submitted insurance claim that has all the necessary correct information without any omissions or mistakes that allows it to be processed and paid promptly.

**Clearinghouse** - This is a service that transmits claims to insurance carriers. Prior to submitting claims the clearinghouse scrubs claims and checks for errors. This minimizes the amount of rejected claims as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPAA standards.

**CMS** - Centers for Medicaid and Medicare Services. Federal agency which administers Medicare, Medicaid, HIPAA, and other health programs. Formerly known as the HCFA (Health Care Financing Administration).

**CMS 1500** - Medical claim form established by CMS to submit paper claims to Medicare and Medicaid. Most commercial insurance carriers also require paper claims be submitted on CMS-1500’s. The form is distinguished by its red ink.

**Coding** - Medical billing coding involves taking the doctors notes from a patient visit and translating them into the proper ICD-9 code for diagnosis and CPT codes for treatment.

**COBRA Insurance** - This is health insurance coverage available to an individual and their dependents after becoming unemployed - either voluntary or involuntary termination of employment for reasons other than gross misconduct. Because it does not typically receive company matching, It's typically more expensive than insurance the cost when employed but does benefit from the savings of being part of a group plan. Employers must extend COBRA coverage to employees dismissed for a. COBRA stands for Consolidated Omnibus Budget Reconciliation Act which was passed by Congress in 1986. COBRA coverage typically lasts up to 18 months after becoming unemployed and under certain conditions extended up to 36 months.

**Co-Insurance** - Percentage or amount defined in the insurance plan for which the patient is responsible. Most plans have a ratio of 90/10 or 80/20, 70/30, etc. For example the insurance carrier pays 80% and the patient pays 20%.

**Contractual Adjustment** - The amount of charges a provider or hospital agrees to write off and not charge the patient per the contract terms with the insurance company.

**Coordination of Benefits** - When a patient is covered by more than one insurance plan. One insurance carrier is designated as the primary carrier and the other as secondary.

**Co-Pay** - Amount paid by patient at each visit as defined by the insured plan.

**CPT Code** - Current Procedural Terminology. This is a 5 digit code assigned for reporting a procedure performed by the physician. The CPT has a corresponding ICD-9 diagnosis code. Established by the American Medical Association.

**Credentialing** - This is an application process for a provider to participate with an insurance carrier. Many carriers now request credentialing through CAQH. CAQH credentialing process is a universal system now accepted by insurance company networks.

**Credit Balance** - The balance that’s shown in the "Balance" or "Amount Due" column of your account statement with a minus sign after the amount (for example $50-). It may also be shown in parenthesis; ($50). The provider may owe the patient a refund.
**Crossover claim** - When claim information is automatically sent from Medicare the secondary insurance such as Medicaid.

**Date of Service (DOS)** - Date that health care services were provided.

**Deductible** - Amount patient must pay before insurance coverage begins. For example, a patient could have a $1000 deductible per year before their health insurance will begin paying. This could take several doctor's visits or prescriptions to reach the deductible.

**Demographics** - Physical characteristics of a patient such as age, sex, address, etc. necessary for filing a claim.

**DOB** - Abbreviation for Date of Birth.

**Downcoding** - When the insurance company reduces the code (and corresponding amount) of a claim when there is no documentation to support the level of service submitted by the provider. The insurers' computer processing system converts the code submitted down to the closest code in use which usually reduces the payment.

**Durable Medical Equipment** – Medical Supplies

**Duplicate Coverage Inquiry (DCI)** - Request by an insurance company or group medical plan by another insurance company or medical plan to determine if other coverage exists.

**Dx** - Abbreviation for diagnosis code (ICD-9 or ICD-10 code).

**Electronic Claim** - Claim information is sent electronically from the billing software to the clearinghouse or directly to the insurance carrier. The claim file must be in a standard electronic format as defined by the receiver.

**Electronic Funds Transfer (EFT)** - An electronic paperless means of transferring money. This allows funds to be transferred, credited, or debited to a bank account and eliminates the need for paper checks.

**E/M** - Evaluation and Management section of the CPT codes. These are the CPT codes 99201 thru 99499 most used by physicians or other qualified staff to access (or evaluate) patients treatment needs.

**EMR** - Electronic Medical Records. This is a medical record in digital format of a patient’s hospital or provider treatment.

**Enrollee** - Individual covered by health insurance.

**EOB** - Explanation of Benefits. One of the medical billing terms for the statement that comes with the insurance company payment to the provider explaining payment details, covered charges, write offs, and patient responsibilities and deductibles.

**ERA** - Electronic Remittance Advice. This is an electronic version of an insurance EOB that provides details of insurance claim payments. These are formatted in according to the HIPAA X12N 835 standard.

**ERISA** - Employee Retirement Income Security Act of 1974. This law established the reporting, disclosure of grievances, and appeals requirements and financial standards for group life and health. Self-insured plans are regulated by this law.

**Fee For Service** - Insurance where the provider is paid for each service or procedure provided. Typically allows patient to choose provider and hospital. Some policies require the patient to pay provider directly for services and submit a claim to the carrier for reimbursement. The trade-off for this flexibility is usually higher deductibles and co-pays.

**Fee Schedule** - Cost associated with each treatment CPT medical billing codes.

**Financial Responsibility** - The portion of the charges that are the responsibility of the patient
or insured.

**Fiscal Intermediary (FI)** - A Medicare representative who processes Medicare claims.

**Formulary** - A list of prescription drug costs which an insurance company will provide reimbursement for.

**Fraud** - When a provider receives payment or a patient obtains services by deliberate, dishonest, or misleading means.

**GPH** - Group Health Plan. A means for one or more employer who provide health benefits or medical care for their employees (or former employees).

**Group Name** - Name of the group or insurance plan that insures the patient.

**Group Number** - Number assigned by insurance company to identify the group under which a patient is insured.

**Guarantor** - A responsible party and/or insured party who is not a patient.

**HCFA** - Health Care Financing Administration. Now known as CMS (see above in Medical Billing Terms).

**HCPCS** - Health Care Financing Administration Common Procedure Coding System. Three level system of codes. CPT is Level I. A standardized medical coding system used to describe specific items or services provided when delivering health services. May also be referred to as a “procedure code” in the medical billing glossary.

The three HCPCS levels are:

- Level II - The alphanumeric codes which include mostly non-physician items or services such as medical supplies, ambulatory services, prosthesis, etc. These are items and services not covered by CPT (Level I) procedures.
- Level III - Local codes used by state Medicaid organizations, Medicare contractors, and private insurers for specific areas or programs.

**Health Savings Account** - A tax advantaged medical savings account available to employees who are enrolled in a High-Deductible health plan. This account is to be used for medical expenses only.

**Healthcare Insurance** - Insurance coverage to cover the cost of medical care necessary as a result of illness or injury. May be an individual policy or family policy which covers the beneficiary’s family members. May include coverage for disability or accidental death or dismemberment.

**Healthcare Provider** - Typically a physician, hospital, nursing facility, or laboratory that provides medical care services. Not to be confused with insurance providers or the organization that provides insurance coverage.

**Health Care Reform Act** - Health care legislation championed by President Obama in 2010 to provide improved individual health care insurance or national health care insurance for Americans. Also referred to as the Health Care Reform Bill or the Obama Health Care Plan.

**HIC** - Health Insurance Claim. This is a number assigned by the Social Security Administration to a person to identify them as a Medicare beneficiary. This unique number is used when processing Medicare claims.

**HIPAA** - Health Insurance Portability and Accountability Act. Several federal regulations intended to improve the efficiency and effectiveness of health care. HIPAA has introduced a lot of new medical billing terms into our vocabulary lately.
HMO - Health Maintenance Organization. A type of health care plan that places restrictions on treatments.

ICD-9 Code - Also known as ICD-9-CM. International Classification of Diseases classification system used to assign codes to patient diagnosis. This is a 3 to 5 digit number.

ICD-10 Code - 10th revision of the International Classification of Diseases. Uses 3 to 7 digit. Includes additional digits to allow more available codes. The U.S. Department of Health and Human Services implementation deadline was October, 2015 for ICD-10.

Indemnity - Also referred to as fee-for-service. This is a type of commercial insurance were the patient can use any provider or hospital.

In-Network (or Participating) - An insurance plan in which a provider signs a contract to participate in. The provider agrees to accept a discounted rate for procedures.

MAC - Medicare Administrative Contractor. Contractors who process Medicare claims.

Managed Care Plan - Insurance plan requiring patient to see doctors and hospitals that are contracted with the managed care insurance company. Medical emergencies or urgent care are exceptions when out of the managed care plan service area.

Maximum Out of Pocket - The maximum amount the insured is responsible for paying for eligible health plan expenses. When this maximum limit is reached, the insurance typically then pays 100% of eligible expenses.

Medical Assistant - A health care worker who performs administrative and clinical duties in support of a licensed health care provider such as a physician, physician’s assistant, nurse, nurse practitioner, etc.

Medical Coder - Analyzes patient charts and assigns the appropriate code. These codes are derived from ICD-9 codes (soon to be ICD-10) and corresponding CPT treatment codes and any related CPT modifiers.

Medical Billing Specialist - Processes insurance claims for payment of services performed by a physician or other health care provider. Ensures patient medical billing codes, diagnosis, and insurance information are entered correctly and submitted to insurance payer. Enters insurance payment information and processes patient statements and payments. Performs tasks vital to the financial operation of a practice. Knowledgeable in medical billing terminology.

Medical Necessity - Medical service or procedure that is performed on for treatment of an illness or injury that is not considered investigational, cosmetic, or experimental.

Medical Record Number - A unique number assigned by the provider or health care facility to identify the patient medical record.

MSP - Medicare Secondary Payer.

Medical Savings Account - Tax exempt account for paying medical expenses administered by a third-party to reimburse a patient for eligible health care expenses. Typically provided by employer where the employee contributes regularly to the account before taxes and submits claims or receipts for reimbursement. Sometimes also referred to in medical billing terminology as a Medical Spending Account.

Medicare - Insurance provided by federal government for people over 65 or people under 65 with certain restrictions:
- Medicare Part A - Hospital coverage
- Medicare Part B - Physicians visits and outpatient procedures
- Medicare Part D - Medicare insurance for prescription drug costs for anyone enrolled in
Medicare Part A or B.

**Medicare Coinsurance Days** - Medical billing terminology for inpatient hospital coverage from day 61 to day 90 of a continuous hospitalization. The patient is responsible for paying for part of the costs during those days. After the 90th day, the patient enters "Lifetime Reserve Days."

**Medicare Donut Hole** - The gap or difference between the initial limits of insurance and the catastrophic Medicare Part D coverage limits for prescription drugs.

**Medicaid** - Insurance coverage for low income patients. Funded by Federal and state government and administered by states.

**Medigap** - Medicare supplemental health insurance for Medicare beneficiaries which may include payment of Medicare deductibles, co-insurance and balance bills, or other services not covered by Medicare.

**Modifier** - Modifier to a CPT treatment code that provide additional information to insurance payers for procedures or services that have been altered or "modified" in some way. Modifiers are important to explain additional procedures and obtain reimbursement for them.

**N/C** - Non-Covered Charge. A procedure not covered by the patients’ health insurance plan.

**NEC** - Not Elsewhere Classifiable. Medical billing terminology used in ICD when information needed to code the term in a more specific category is not available.

**Network Provider** - Health care provider who is contracted with an insurance provider to provide care at a negotiated cost.

**Non-participation (Non-Par)** - When a healthcare provider chooses not to accept Medicare approved payment amounts as payment in full.

**NOS** - Not Otherwise Specified. Used in ICD for unspecified diagnosis.

**NPI Number** - National Provider Identifier. A unique 10 digit identification number required by HIPAA and assigned through the National Plan and Provider Enumeration System (NPPES).

**OIG** - Office of Inspector General - Part of department of Health and Human Services. Establish compliance requirements to combat healthcare fraud and abuse. Has guidelines for billing services and individual and small group physician practices.

**Out-of-Network (or Non-Participating)** - A provider that does not have a contract with the insurance carrier. Patients usually responsible for a greater portion of the charges or may have to pay all the charges for using an out-of-network provider.

**Out-Of-Pocket Maximum** - The maximum amount the patient has to pay under their insurance policy. Anything above this limit is the insurers’ obligation. These Out-of-pocket maximums can apply to all coverage or to a specific benefit category such as prescriptions.

**Outpatient** - Typically treatment in a physician’s office, clinic, or day surgery facility lasting less than one day.

**Patient Responsibility** - The amount a patient is responsible for paying that is not covered by the insurance plan.

**PCP** - Primary Care Physician - Usually the physician who provides initial care and coordinates additional care if necessary.

**POS** - Point-of-Service plan. Medical billing terminology for a flexible type of HMO (Health Maintenance Organization) plan where patients have the freedom to use (or self-refer to) non-HMO network providers.
**POS (Used on Claims)** - Place of Service. Medical billing terminology used on medical insurance claims - such as the CMS 1500 block 24B. A two digit code which defines where the procedure was performed. For example 71 is for the Health Departments and 12 is for home.

**PPO** - Preferred Provider Organization. Commercial insurance plan where the patient can use any doctor or hospital within the network. Similar to an HMO.

**Practice Management Software** - software used for the daily operations of a provider’s office. Typically used for appointment scheduling and billing.

**Preauthorization** - Requirement of insurance plan for primary care doctor to notify the patient insurance carrier of certain medical procedures (such as outpatient surgery) for those procedures to be considered a covered expense.

**Pre-Certification** - Sometimes required by the patients insurance company to determine medical necessity for the services proposed or rendered. This doesn’t guarantee the benefits will be paid.

**Predetermination** - Maximum payment insurance will pay towards surgery, consultation, or other medical care - determined before treatment.

**Pre-existing Condition (PEC)** - A medical condition that has been diagnosed or treated within a certain specified period of time just before the patient’s effective date of coverage. A Preexisting condition may not be covered for a determined amount of time as defined in the insurance terms of coverage (typically 6 to 12 months).

**Pre-existing Condition Exclusion** - When insurance coverage is denied for the insured when a pre-existing medical condition existed when the health plan coverage became effective.

**Premium** - The amount the insured or their employer pays (usually monthly) to the health insurance company for coverage.

**Privacy Rule** - The HIPAA privacy standard establishes requirements for disclosing what the HIPAA privacy law calls Protected Health Information (PHI). PHI is any information on a patient about the status of their health, treatment, or payments.

**Provider** - Physician or medical care facility (hospital) who provides health care services.

**PTAN** - Provider Transaction Access Number. Also known as the legacy Medicare number.

**Referral** - When one provider (usually a family doctor) refers a patient to another provider (typically a specialist).

**Relative Value Unit** – Measure of value used by Medicare to determine how much to reimbursement for a procedure by using a formula.

**Remittance Advice (R/A or RA)** - A document supplied by the insurance payer with information on claims submitted for payment. Contains explanations for rejected or denied claims. Also referred to as an EOB (Explanation of Benefits).

**Responsible Party** - The person responsible for paying a patient’s medical bill. Also referred to as the guarantor.

**Self-Referral** - When a patient sees a specialist without a primary physician referral.

**Self Pay** - Payment made at the time of service by the patient.

**Secondary Insurance Claim** - claim for insurance coverage paid after the primary insurance makes payment. Secondary insurance is typically used to cover gaps in insurance coverage.

**Secondary Procedure** - When a second CPT procedure is performed during the same physician visit as the primary procedure.

**Security Standard** - Provides guidance for developing and implementing policies and
procedures to guard and mitigate compromises to security. The HIPAA security standard is kind of a sub-set or compliment to the HIPAA privacy standard. Where the HIPAA policy privacy requirements apply to all patient Protected Health Information (PHI), HIPAA policy security laws apply more specifically to electronic PHI.

**SOF** - Signature on File.

**Specialist** - Physician who specializes in a specific area of medicine, such as urology, cardiology, orthopedics, oncology, etc. Some healthcare plans require beneficiaries to obtain a referral from their primary care doctor before making an appointment to see a Specialist.

**Subscriber** - Medical billing term to describe the employee for group policies. For individual policies the subscriber describes the policyholder.

**Superbill** - One of the medical billing terms for the form the provider uses to document the treatment and diagnosis for a patient visit. Typically includes several commonly used ICD-9 diagnosis and CPT procedural codes. One of the most frequently used medical billing terms.

**Supplemental Insurance** - Additional insurance policy that covers claims for deductibles and coinsurance. Frequently used to cover these expenses not covered by Medicare.

**TAR** - Treatment Authorization Request. An authorization number given by insurance companies prior to treatment in order to receive payment for services rendered.

**Taxonomy Code** - Specialty standard codes used to indicate a provider’s specialty sometimes required to process a claim.

**Term Date** - Date the insurance contract expired or the date a subscriber or dependent ceases to be eligible.

**Tertiary Insurance Claim** - Claim for insurance coverage paid in addition to primary and secondary insurance. Tertiary insurance covers gaps in coverage the primary and secondary insurance may not cover.

**Third-Party Administrator (TPA)** - An independent corporate entity or person (third-party) who administers group benefits, claims and administration for a self-insured company or group.

**TIN** - Tax Identification Number. Also known as Employer Identification Number (EIN).

**TOP** - Triple Option Plan. An insurance plan which offers the enrolled a choice of a more traditional plan, an HMO, or a PPO. This is also commonly referred to as a cafeteria plan.

**TOS** - Type of Service. Description of the category of service performed.

**TRICARE** - This is federal health insurance for active duty military, National Guard and Reserve, retirees, their families, and survivors. Formerly known as CHAMPUS.

**UB04** - Claim form for hospitals, clinics, or any provider billing for facility fees similar to CMS 1500. Replaces the UB92 form.

**Unbundling** - Submitting several CPT treatment codes when only one code is necessary.

**Untimely Submission** - Medical claim submitted after the time frame allowed by the insurance payer. Claims submitted after this date are denied.

**Upcoding** - An illegal practice of assigning an ICD-9 diagnosis code that does not agree with the patient records for the purpose of increasing the reimbursement from the insurance payer.

**UPIN** - Unique Physician Identification Number. 6 digit physician identification number created by CMS. Discontinued in 2007 and replaced by NPI number.

**Utilization Limit** - The limits that Medicare sets on how many times certain services can be provided within a year. The patients claim can be denied if the services exceed this limit.

**Utilization Review (UR)** - Review or audit conducted to reduce unnecessary inpatient or
outpatient medical services or procedures.

**V-Codes** - ICD-9-CM coding classification to identify health care for reasons other than injury or illness.

**Workers Comp** - Insurance claim that results from a work related injury or illness.

**Write-off** - Typically reference to the difference between what the physician charges and what the insurance plan contractually allows and the patient is not responsible for. May also be referred to as "not covered" in some glossary of billing terms.
Resources


http://www.ahip.org/Archived-Webinars-Immunization/

http://archived.naccho.org/toolbox/

http://archived.naccho.org/topics/HPDP/billing/

http://www.cdc.gov/phlp/docs/hd-billing.pdf

http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html#il


http://www.hfs.illinois.gov/html/093013n.html

http://www.dph.illinois.gov/topics-services/prevention-wellness/immunization

http://www.dph.illinois.gov/topics-services/prevention-wellness/immunization/icare

http://www.dph.illinois.gov/laws-rules


http://www.immunize.org/clinic/coding-billing.asp


http://www.nvic.org/Vaccine-Laws/state-vaccine-requirements/illinois.aspx


https://www.cms.gov/Medicare/Prevention/Immunizations/Providerresources.html


IMPORTANT MESSAGE FOR VFC PROGRAMS

TO: Local and Municipal Health Departments Participating in Vaccines For Children (VFC)
Local Health Department staff performing third-party billing, and
Local Health Department (LHD) Administrators

FROM: Carol Gibson Finley, Acting Chief, Immunization Section

CC: Regional VFC Staff and VFC Contractors

DATE: February 2, 2016

SUBJECT: Intricacies in Billing Operations with VFC-supplied Vaccines

This memo is to inform all local and municipal health departments (LHDs) of four routine processes identified that may be problematic in the process of billing insurers, Medicaid, and/or Medicare for vaccine and vaccine administration fees.

1. **It is the responsibility of all health care providers to fully screen patients for VFC eligibility** to ensure that fully insured patients, or patients 19 years of age and older, do not receive VFC-supplied vaccine intended for VFC-eligible children and children who are served through Medicaid’s All Kids program. Providers should encourage patients to review insurance benefits when scheduling and have staff confirm benefits.

   **If a patient arrives for an appointment at an LHD and staff is still unsure of patient benefits coverage, vaccination should be deferred until insurance coverage question(s) can be answered.**

2. It is critical to remember that Federally-supplied vaccines cannot be administered to privately insured persons.
   • When administering VFC-supplied vaccines, VFC providers can only bill Medicaid for vaccine administration costs.
   • Vaccines For Adults (VFA) vaccines may only be provided to the uninsured and underinsured. VFA vaccines may not be administered to patients with Medicaid or Medicare.

   **Providers wishing to serve the privately insured and bill insurers for both vaccine and administration costs must purchase vaccines privately to address the needs of privately insured patients.**

3. Children who are privately insured and also have Medicaid, either as primary or secondary insurance, are eligible to receive VFC vaccines.
• When considering using privately purchased vaccines and billing the private insurer for vaccine and administration costs, provider staff should ensure that the private insurance will cover vaccinations before private vaccine inventory is used.
• If staff administers VFC vaccine, only the vaccine administration costs can be billed to Medicaid. Vaccine administration payment fees from a private insurer would be greater than the $6.40 paid by Medicaid, but if VFC vaccine is used, private insurers cannot be billed.

We have received information that the Medicaid agency, Illinois Healthcare and Family Services (HFS), is not allowing reimbursement for these children with dual insurance unless the private insurer refuses payment. We are working with staff at HFS to ensure that HFS correctly utilizes and supports the federally mandated allowance for VFC vaccine use and administration cost reimbursement under these circumstances.

4. Underinsured children can only receive VFC vaccine at a federally qualified health center (FQHC), rural health clinic (RHC) or a local health department (LHD) deputized by a FQHC or RHC to serve the underinsured. Underinsured children include those under age 19 years whose private coverage does not include any vaccinations, or does not provide all ACIP recommended vaccinations, or whose coverage places caps on the allowed number of provider visits or caps services once a certain dollar amount is reached.
   • When administering VFC vaccines to non-Medicaid children who meet one of the criteria listed above, VFC providers are not allowed to charge or bill non-Medicaid VFC eligible children for the cost of the VFC vaccine.
   • VFC providers may charge a vaccine administration fee; the current vaccine administration fee may not exceed the administration fee cap of $23.87 per vaccine dose.
   • However, the administration fee must be waived if the parent (or child) cannot afford to pay.

The Immunization section continues to collaborate with the Illinois Public Health Association (IPHA) to facilitate local and municipal health departments (LHDs) to implement initiatives to receive competitively priced vaccines for use with privately-insured patients and to routinely bill public and private insurers for immunization services provided.
   • IPHA continues to provide reduced cost vaccine purchasing consortium services in their collaborations with FFF Enterprises and the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP).
   • IPHA’s billing initiative relies on an association with a billing vendor, CDP, Inc., to assist LHDs to become credentialed and contracted with key insurers operating within their area and to perform billing on behalf the LHDs.

If you have any questions about this guidance, please contact me at the Immunization section at 217-785-1455 or by e-mail at carol.finley@illinois.gov.

Please review and post all VFC notices so that all staff involved in vaccine administration, management, patient screening, and billing are aware and receive updated protocols as necessary to comply with VFC program requirements.
**Immunization Billing Project Generates More Than $1 Million in Paid Claims Revenue**

IPHA is pleased to announce that the Immunization Billing Project funded by the Centers for Disease Control and Prevention through the Illinois Department of Public Health has reached another significant milestone.

As of March 31, 2016, the health departments that are participating in the implementation phase of this project have now received more than $1 million paid claims!

During the month of March 2016 alone, twenty local health departments collectively earned $224,932.17 in revenue from paid claims. The total claims revenue from July 2015 through March 2016 is **$1,082,593.31**. This revenue is from commercial payers, as well as Medicare and Medicaid, and is not money that is dependent on state or federal grant funding.

For LHDs that have not yet taken the opportunity to move into the realm of billing for preventive services, it is not too late. IPHA stands ready to assist LHDs who wish to explore this opportunity, which will remain in force through the summer of 2016. Please contact Phil Talley, Billing Project Manager at ptalley@ipha.com or Lanie Cooper, Project Associate at lcooper@ipha.com.
### Addendum B – Sample Superbill

**SAMPLE BILLING FORM**

**County Department of Public Health**

**Date of Service:** [Please Print] **Client’s Name:**

**Mailing Address:**

**Phone Number:** [Please Print] **Zip Code:**

**Date of Birth:**

**Parent/Guardian’s Name:**

#### IMMUNIZATIONS

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<td>Shingles</td>
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<td>TD</td>
<td>V06.5</td>
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<tr>
<td>Tdap</td>
<td>V06.1</td>
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<td>Typhoid</td>
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<td>Varicella</td>
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#### LAB SERVICES

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<tr>
<th>DX</th>
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<tbody>
<tr>
<td>Chlamydia Screen</td>
<td>V73.98</td>
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<tr>
<td>Gonorrhea Screen</td>
<td>V74.5</td>
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<td>HIV Screen</td>
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<td>Syphilis Screen</td>
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<td>HIV Counseling-15 min</td>
<td>V65.44</td>
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<tr>
<td>STD Counseling-15 min</td>
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#### NURSING SERVICES

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<td>Health Risk Post Natal</td>
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<td>Hearing Screening</td>
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<td>Infections (serum provided by client, i.e. B12)</td>
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<td>99610</td>
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<tr>
<td>Oral Syringe Pre-fill (Max 2 weeks)</td>
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<td>Routine Infant 0-12 Mo, NEW</td>
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<td>Vision Screening Child</td>
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<td>Pediatric 6-35 months</td>
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<td>Adult 21-35 years</td>
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<td>High Dose 65+</td>
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#### EXTRAS

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<td>Vaccine Adm/1 Toxoid 0-18 yrs</td>
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**Total Charges for Services**

* [ ] Cash
* [ ] Check

**Co-Pay**

**Additional Amount Paid**

**BALANCE DUE**

* [ ] Cash
* [ ] Check

**Nurse:**

**Comments:**