Enrollment

Enrollment[5]

Enrollment is the process of applying to and receiving permission from a third-party payer for an applicant to receive reimbursements for allowable services delivered to covered patients. Depending on the payer, the applicants may be Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), Advanced Practice Nurses (APNs), Physician Assistants (PAs) and/or the LPHA itself. The information in this section is intended to aid LPHAs with the enrollment process.

Health Insurance Portability and Accountability Act of 1996[6,7,8]

The Health Insurance Portability and Accountability Act (HIPAA) was established in 1996. The Administrative Simplification standards adopted by the Department of Health and Human Services (HHS) under HIPAA apply to any entity that is a health care provider that conducts certain transactions in electronic form, a health care clearinghouse or a health plan. An organization that is one or more of these types of entities is referred to as a "covered entity" in the Administrative Simplification regulations.

Below is a summary of the various rules associated with HIPAA.

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. The Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

Fast Fact

HIPAA was enacted to help covered entities protect the privacy of their clients.

The HIPAA Security Rule specifies a series of administrative, physical and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity and availability of electronic protected health information.

The HIPAA Breach Notification Rule requires covered entities and their business associates to provide notification following a breach of unsecured protected health information.

The HIPAA Patient Safety Rule protects identifiable information being used to analyze patient safety events and improve patient safety.

Additional information regarding HIPAA can be found at https://www.hhs.gov/hipaa.

National Provider Identifier[9]

All HIPAA-covered health care providers are legally required to obtain a National Provider Identifier (NPI). A NPI is a 10-digit number that is used to identify health care providers in HIPAA standard transactions.

NPI numbers simplify electronic submission of HIPAA standard transactions and make the coordination of benefit transactions more efficient.

Health care providers can apply for a NPI number through the Centers for Medicare and Medicaid Services' (CMS) National Plan and Provider Enumeration System (NPPES).

The NPI must be used in HIPAA standard transactions in place of legacy provider identifiers such as a Unique Provider Identification Number (UPIN), Online Survey Certification and Reporting (OSCAR) and National Supplier Clearinghouse (NSC). The use of a NPI allows for simple electronic transmission of HIPAA standard transactions and makes the coordination of benefit transactions more efficient.

Additional information regarding NPI numbers can be found in the Centers for Medicare and Medicaid Services' fact sheet The National Provider Identifier (NPI): What You Need to Know, located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf.

A NPI application / update form can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10114.pdf.

Taxonomy Codes[10]

Health care provider taxonomy codes are used to categorize the type, classification and/or specialization of health care providers. A provider must select the taxonomy code that adequately describes their type, classification and/or specialization when applying for their NPI through NPPES. Multiple taxonomy codes may be selected; however, one must be indicated as the primary.

For more information on health care provider taxonomy codes, visit cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/taxonomy.html.

A listing of health care provider taxonomy codes can be found at cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/taxonomycrosswalk.pdf.

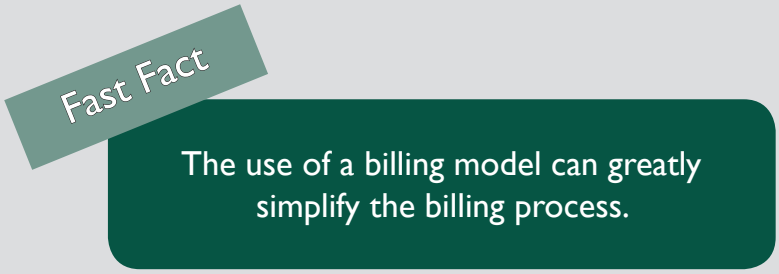
Billing Models[3,11]

Electronic medical billing has many potential advantages over paper, especially time savings. For agencies billing multiple plans, a billing model (i.e., clearinghouse, billing software or immunization service provider) can improve and streamline the claims submission process further.

A clearinghouse is a business functioning as an intermediary between billing staff and third-party payers retransmitting claims to all third-party payers. In essence, they are regional post offices enabling health care providers to transmit electronic claims to insurance carriers. Clearinghouses offer billers or office managers a central location to manage their claims. The cost to utilize a clearinghouse will vary among different vendors. Many clearinghouses either charge a monthly fee or base their fees on the volume of claims being submitted by the agency.

Billing Models[3,11] *continued*

Billing software, also referred to as a practice management system, is used to implement the billing process and assists with the management of day-to-day operations of the agency. The software allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, post payment information, follow-up on denied claims and generate reports. Billing software can come in the form of desktop software that is loaded onto a computer; client-server software that is accessed through a server by multiple users; or Internet-based software that is accessed by an unlimited number of users through a software vendor's remote server. The cost of billing software will vary among different vendors.



An immunization service provider is an organization that provides vaccines, claims processing and patient billing. Through this type of service, LPHAs can order vaccine at no cost and will then be reimbursed a specified amount for each vaccine administered.

Piloted Billing Models

LPHAs pilot tested various billing models during the grant projects. The billing models included: Availity, HeW, TransactRx, Upp Technology, Emdeon One, and VaxCare. Contact information for the billing models can be found in the *Appendices* of this toolkit. Reviews on the billing models varied among the LPHAs. All of the billing models tested were web-based medical claims clearinghouses except for VaxCare. VaxCare is a third-party immunization service provider that offers vaccines, claims processing and patient billing.

Through VaxCare, LPHAs pay a monthly fee and order vaccines and supplies on an as needed basis from the VaxCare on-line portal at no cost. Agencies are compensated at the rate of approximately $10 per immunization for all vaccines. LPHAs utilizing this billing model are not required to have contracts with private / commercial insurance companies.

The other billing models require an LPHA to purchase private stock vaccine and obtain contracts with private / commercial insurance companies. The essential services and processing costs for public and private claims vary and may or may not include start-up costs, monthly or annual fees, and/or independent claim fees. However, since the LPHAs obtain contracts with the private / commercial companies they can negotiate their reimbursement rates and have more flexibility in generating revenue.

All of the billing models piloted offered unlimited on-line training and customer support services. Some models may provide on-site training.

Billing Model Selection[3]

There are many billing models available for use by LPHAs. It is critical to select a model that is sustainable for the agency. In order to select the proper billing model, agencies should conduct a thorough assessment to determine their individual needs. Once the LPHA's needs assessment has been completed, a billing model can be matched accordingly.

Each of the pilot project billing models offer a variety of billing services that could be beneficial to LPHAs.

If the LPHA is unsure whether the agency would benefit from the services of a billing model, they should consider a trial period with a billing model that offers a month-to-month subscription option. Contact customer service in advance and ask for a quick tour of the product. Make certain that claim errors and rejections are reported in plain language, not as shorthand numeric codes.

"Free" may not mean best value or even lowest long term cost. Decide whether the LPHA needs full service help or help with only a portion of the process. Be sure to review the agency's bidding and contracting policies before making any commitments to a billing model that charges for services.

The Cost Analysis tool developed for the LPHA pilot project can be utilized to monitor the sustainability of a billing model and is included in the *Appendices* of this toolkit.

CMS-1500 Claim Form[12]

The CMS-1500 is the standard claim form used for paper claims submission to bill Medicare Fee-For-Service (FFS) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. The form may also be suitable for billing other government programs and some private / commercial insurers. Additional information regarding ASCA waivers is located at cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html.

The National Uniform Claim Committee (NUCC) is responsible for the design of the CMS-1500. A printed download or photocopy of the form cannot be used for claims submission, as it may not accurately replicate the colors within the form. The colors in the form are needed to enable electronic reading of the information. Orders for forms can be completed by contacting the U.S. Government Printing Office at 866.512.1800 or through local printing companies and/or office supply stores, as long as they print according to the CMS approved specifications found in the Medicare Claims Processing Manual (IOM Pub. 100-04, Chapter 26, Section 30).

For additional information on the CMS-1500, visit cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html or the National Uniform Claim Committee at nucc.org.

The Form CMS-1500 At A Glance fact sheet can be found at networkhealth.com/_files/pdf/provider/medicare/cms-1500%20Fact%20Sheet.pdf.

A copy of the CMS-1500 can be found at cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf.

Current Procedural Terminology Codes[13,14]

Current Procedural Terminology (CPT®) codes are developed and maintained by the American Medical Association (AMA) and are intended to support billing for services. CPT® codes are the most widely accepted medical classifications used to report medical procedures and services under public and private / commercial health insurance programs. The codes are universal and help to ensure uniformity. CPT® codes are used to identify immunization and other services provided by LPHAs on claim forms and other billing materials. Vaccines, administration fees and office visits are reported using separate CPT® codes.

For more information on CPT codes, visit https://www.ama-assn.org/practice-management/find-coding-resources.

Credentialing[15,11,3]

Credentialing is the process of assessing and confirming the qualifications of a licensed or certified health care practitioner. It is an important and complex process that includes collecting and verifying information about a practitioner, assessing and interpreting the information and making decisions about the practitioner. Before insurance companies will pay medical claims, the public health agency and/or its health care providers, must be credentialed as participating providers. This includes MDs, DOs, APNs, PAs and the agency itself. In medical billing, an individual or agency is only considered a participating provider when they have been credentialed and then receive a contract from an insurance company.

Credentialing is the cornerstone in an insurance company's risk management; helping protect themselves, the public and providers from fraud. It thoroughly documents the identity, education and professional credentials of providers and discloses malpractice suits, claims history, license restrictions or sanctions occurring in the past. The credentialing process may reflect a health care provider's ability to practice and their professional competence. Ultimately, credentialing is used to analyze and qualify applicants seeking to provide health care services to an insurance company's policy holders.

Fast Fact

Credentialing helps protect insurance companies, the public and providers from fraud.

When credentialing is successfully completed, the insurance company will offer a contract to the LPHA. The contract will define responsibilities of both parties, as well as the fee schedule. The credentialing process can begin once the decision is made to pursue a contract with a third-party payer (i.e., become a participating provider).

LPHAs should consider identifying a staff person to serve as a liaison with third-party payers for the purpose of credentialing. The agency should ensure that their third-party payer liaison has access to the information needed for the credentialing application. This staff member should remain the primary point of contact for payers throughout the credentialing process.

Credentialing Application[16]

The State of Missouri has adopted the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource form (Form UCDS) for credentialing and re-credentialing purposes. All Health Maintenance Organizations (HMOs) and their credentialing agents operating in Missouri are required to accept the paper CAQH Form UCDS. HMOs and their credentialing agents may accept the electronic CAQH Form UCDS. HMOs and their credentialing agents that develop their own electronic systems for gathering and storing credentialing data must also accept paper submission of the CAQH Form UCDS.

It is important to understand that only HMOs are required by law to use and accept this form. Since HMOs are a small fraction of the private / commercial insurance market, LPHAs should expect to encounter non-standard credentialing forms from non-HMO private insurers, who are the vast majority of insurers doing business in Missouri.

More information regarding the CAQH Form UCDS is located at insurance.mo.gov/industry/filings/mc/hmocredentialing.php or at caqh.org/solutions/caqh-proview.

The State of Missouri utilizes the Council for Affordable Quality Healthcare's Universal Credentialing DataSource form (Form UCDS) for HMO credentialing and re-credentialing.

Credentialing Documents[17]

The documents needed for the credentialing application include the following items. Please note that some documents may not apply to all provider types.

- CAQH Form UCDS (credentialing application)
- A list of societies of which you are currently a member
- Application release – stamped signatures not accepted
- Board Certification Certificate
- Clinical Laboratory Improvement Amendment (CLIA) waiver number and identification number (or copy of certificate)
- Collaborative practice and/or physician assistant agreement(s)
- Copies of all postgraduate (CME) activities credited in the last two years
- Copies of professional diplomas and training certificates as applicable
- Current certificates of insurance
- Current state licenses
- Curriculum vitae
- Education Council for Foreign Medical Graduates (ECFMG) certificate
- Federal Drug Enforcement Administration (DEA) certificate
- Signed Malpractice claims history
- State controlled substance certificates for all states (i.e., Bureau of Narcotics and Dangerous Drugs certificate)
- United States Military discharge papers (DD214) or status if currently serving
- Internal Revenue Service Form W9

Credentialing Documents[17] *continued*

An electronic filing system with scanned documents is the best form of recordkeeping for the credentialing process; however, a paper filing system would be sufficient. Many of the above mentioned documents will be needed throughout the credentialing process. Credentialing document requirements will vary among the different insurance companies.

CAQH Universal Provider Datasource[18,19,20]

The CAQH Universal Provider Datasource (UPD) is a free, web-based repository used to collect medical provider credentialing data. UPD is a secure, centralized database in which health care providers may submit their credentialing information free of charge. There are various Missouri insurance companies that utilize UPD for provider credentialing, including: Aetna, Anthem Blue Cross of Missouri, Blue Cross Blue Shield of Kansas City, Cigna HealthCare, Coventry Health Care, HealthLink, Inc., Humana/Choice Care Network, United Healthcare, WellCare and WellPoint.

Fast Fact

Many of Missouri's top insurance companies utilize the CAQH UPD for provider credentialing.

The following steps are required to complete the initial CAQH application process.

1. Register with the system at proview.caqh.org/PR/Registration.
2. Complete all application questions.
3. Complete an audit of the application data.
4. Review the application data summary.
5. Authorize participating organizations access to the application data.
6. Attest to the application data.
7. Print the fax cover page.
8. Fax the requested supporting documentation.

For additional information on the CAQH UPD, visit proview.caqh.org/Login/Index?ReturnUrl=%2f or refer to the CAQH Universal Provider Datasource Quick Reference Guide for Providers and Practice Managers at caqh.org/sites/default/files/solutions/proview/guide/PM-QuickRef.pdf or the Universal Provider Datasource Provider and Practice Administrator Quick Reference Guide at caqh.org/sites/default/files/solutions/proview/guide/UPDbrochure.pdf.

Common Third-Party Payers

As an agency begins credentialing, it is important to learn about some of the most common third-party payers in their jurisdiction. Being credentialed with the most common insurance companies will allow the LPHA to serve more insured patients. It may be beneficial to begin the credentialing process by visiting the web site of each insurance company to confirm requirements and secure current credentialing forms. Contacting each company to verify the process is essential, as credentialing forms and requirements change frequently.

A contact list of commonly used health insurance companies in Missouri can be found in the *Appendices* of this toolkit.

Facility vs. Individual Credentialing[11]

Credentialing processes vary from one insurance company to another. While required information and documentation may be similar, processes are very different. The credentialing options include: individual, group or facility or a combination of both. Some insurance companies offer all three, some two and some will only credential individual providers.

Individual credentialing is offered by all insurance companies. This allows individual providers to be credentialed and contracted. This links an individual provider's NPI to the agency's organizational NPI and tax identification number (tax ID). When completed, the provider is granted participating provider status. If an agency only bills for immunizations with these companies, it is necessary to credential individual providers.

Group or facility credentialing is not offered by all insurance companies. This option involves credentialing the organization rather than individual providers. If an agency is only planning to bill for immunization services delivered under standing orders from the medical director, this is the credentialing needed. Terminology used by insurance companies varies, with one company referring to this process as a public health agency contract rather than a group or facility contract.

A third option is to seek credentialing both as individuals and a group. This will allow the agency to operate as a mass immunizer that functions under the orders of a medical director and offer clinic type services provided by mid-level providers or MDs and DOs. This situation will require two organizational NPI numbers under the same tax ID number. One NPI will be listed with a taxonomy code identifying the agency as a public health agency. The second NPI will be listed with a family practice clinic or another taxonomy code that best defines the agency. Each will be credentialed with different contracts.

Public health agencies do not represent the common business model for providing health care services; therefore, they are treated differently by most insurance companies. It is essential to verify each company's credentialing requirements for public health agencies.

Roster Billing[21]

Roster billing is a simplified billing process that allows mass immunizers to submit one claim form with a list of several immunized Medicare beneficiaries. CMS defines a mass immunization roster biller as a Medicare-enrolled provider that offers influenza and/or pneumococcal immunizations to a large number of individuals (note: Medicare does not allow roster billing for hepatitis B immunizations). A mass immunizer can be a traditional Medicare provider or supplier, hospital outpatient department, supermarket, pharmacy or public health clinic. Roster bills can be submitted electronically or via paper.

For additional information on roster billing, visit cms.gov/Medicare/Prevention/Immunizations/Providerresources.html or refer to the Mass Immunizers and Roster Billing Fact Sheet at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mass_Immunize_Roster_Bill_factsheet_ICN907275.pdf.

Roster billing is a simple way for mass immunizers to bill Medicare for influenza and/or pneumococcal vaccinations administered to a large number of Medicare benificiaries.

The Welcome Letter[11]

Most insurance companies require 60 to 90 days for the credentialing and contracting processes to be completed. However, some companies allow up to 180 days to process credentialing applications. Credentialing is complete when the LPHA receives a welcome letter from the insurance company. All insurance companies confirm participating provider status with a letter.

The welcome letter will include the official "effective date of service" for each plan along with a copy of the signed contracts and a fee schedule. In some cases, the effective date may be several weeks after receipt of the welcome letter.

LPHAs should schedule patient appointments after the written effective date to avoid lost revenue.

Contracting[11]

The contract between an LPHA or an individual provider and an insurance company is used to accomplish the following:

- Establish a legal relationship with the insurance company;
- Define the provider's responsibilities when delivering services to plan members;
- Establish the claim filing process;
- Detail the procedure for the issuance of payments;
- Define the fee schedule, which sets the amount an insurer will pay for each CPT® code billed by the LPHA; and
- Detail requirements regarding co-payments, deductibles and other factors affecting the LPHA billing program.

The Contracting Process[11,3]

Contracting with insurance companies may not always be well-defined and the process of getting a contract will vary.

With some insurance companies, contracts are either downloaded or ordered from the company prior to completing the credentialing forms. With others, the contracts are delivered after approval as a participating provider.

When a contract is received, the LPHA should review the terms to determine whether or not it will work for the agency. The fundamental question that most LPHAs ask while considering a contract is, "Can we afford to accept the reimbursement rates that the carrier is offering?" Participating providers are reimbursed according to the rates set by the contract and listed in the insurance company's fee schedule. Pay particular attention to all contract language related to reimbursement.

Fast Fact

The contracting process will vary among the different insurance companies.

The Contracting Process[1,3] *continued*

It is important to mention that provider network access can be sold to other insurance companies or third parties (self-insured employer groups). In such an instance, the reimbursement rate will be applicable to consumers who have bought an insurance policy on their own and those who get their coverage from self-insured employers. Remember, DIFP does not regulate self-insured group health insurance plans and Missouri insurance laws do not apply to them. This means that the LPHA could be getting a higher volume of patients than they would otherwise anticipate that may figure into their cost estimations. If the contract is not clear, LPHAs should ask if the health insurance company will be renting their network.

Ask the LPHA legal advisor(s) to determine if the contract is consistent with all applicable laws and regulations. Many insurance companies operate in multiple states and their contracts may not be fully consistent with Missouri laws.

A contact list of commonly used health insurance companies can be found in the *Appendices* of this toolkit. Some private / commercial companies may be subsidiaries to major national companies (example: UMR/ United Medical Resources is a subsidiary of United Health Care). A subsidiary is a company with voting stock that is more than 50% controlled by another company, usually referred to as the parent company or the holding company. A subsidiary is partly or completely owned by the parent company, which holds a controlling interest in the subsidiary company.

Negotiations[3]

Insurance companies have standard provider agreements that they may be reluctant to alter—even in situations where contract language or terms are clearly inappropriate to LPHAs. The BI partnered with DIFP to communicate the importance of modified contracts for Missouri LPHAs during the July 2013 Insurance Summit. As a result of the Summit, top carriers agreed to provide modified contracts to LPHAs throughout the state.

Each agency should attempt to negotiate a contract that best suits their public health format. The best asset in negotiations is a convincing case for improving health care access for the insurance company's membership. It pays to be prepared when negotiating a contract with private / commercial insurance companies. The more an LPHA knows about how they are meeting the health care needs of a particular insurance company the better. Document the number of members that the agency is seeing on a monthly or annual basis and determine which services these individuals typically seek. The Standard Client Surveys included in the *Appendices* of this toolkit can aid in documenting the number of members seen at the LPHA. Be prepared to share information on how the agency is responding to the needs of insurance plan members.

It is important for the LPHA to obtain a modified contract that is appropriate for the individual agency.

Negotiations[3] *continued*

Research the range of immunization and other benefits and reimbursement rates that insurers offer in the local area. If particular language or terms contained in the proposed contract would be problematic, the agency may want to draft and propose language specific to their situation. Keep in mind that simple, straightforward modifications have the greatest chance of success.

Negotiations can help resolve some of the difficulties and barriers that the standard provider services agreements often present, such as liability insurance requirements and the duration of claim periods. During negotiations, an LPHA may request that provisions geared more towards private providers be removed. If the LPHA cannot comply with a provision of the standard agreement, consider an alternative approach. For example, it may be possible to comply by submitting a statement explaining how a particular situation would be managed by the LPHA.

If the proposed fee schedule is inadequate to cover costs, the LPHA may want to make a counter proposal based on a cost analysis.

Under the best of circumstances, it can take weeks to finalize the terms of a contract and get final approvals.

Memorandum of Understanding[3]

An insurance company may propose a written document called a Memorandum of Understanding (MOU) in lieu of, or in addition to, a provider services agreement or other contract type. An MOU can be a good option when the company is unwilling or unable to modify a standard contract to the degree necessary for the LPHA. A successful relationship developed through an MOU may evolve into an agency-specific contract at some point in the future.

Although MOUs can be written so as to be legally binding, an MOU is often less formal and will not necessarily be enforceable. Unless the LPHA legal advisor(s) indicates otherwise, do not expect to have any recourse if the terms of an MOU are no longer observed by the insurance company.

Out-of-Network Provider[11]

In rare instances, it is possible to receive reimbursement from some insurance companies when the provider or agency is not a participating provider, but is an out-of-network provider. When out-of-network providers receive compensation for services, it is significantly less compared to a participating provider, if payment is received at all. Generally, out-of-network providers are not compensated for services. In some cases, insurance companies will send the out-of-network payment directly to the patient. This will require the LPHA to collect payment from the patient, which is not an easy task. Often, patients are required to meet pre-established deductible amounts before being eligible to receive reimbursement for services delivered by an out-of-network provider. If a patient has not met the deductible, providers are faced with billing the patient or writing off the charges to bad debt or collections.

It is likely that some clients will present insurance cards for non-participating provider insurance companies. If out-of-network, call the telephone number on the back of the card to determine if reimbursement can be received by a non-participating provider. This call should be made prior to delivering any services to the client.

Billing as an out-of-network provider is not recommended; however, all LPHAs should be aware of this option.

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