

Section 8 – Financial Policy

Table of Contents

Financial Policy	3
Developing and maintaining charges	3
Create a Maintenance Database.....	3
Medicare Physician Fee Schedule	4
Usual and Reasonable or Customary Charges.....	9
Components of Establishing Usual & Customary Rates (UCR).....	10
Private Supply Vaccine Charge.....	11
Administration Fee	11
<i>Important Coding Note</i>	12
<i>Medicaid Administration Fee</i>	15
<i>Medicare Part B Administration Fee</i>	15
<i>Medicare Part D Administration Fee</i>	15
Sliding Fee Schedules.....	16
Accounts Receivable and Collections	17
<i>Residency Requirements</i>	17
<i>Fee and Payment Expectations</i>	18
<i>Third Party Billing Expectations</i>	18
<i>Client Payment Expectations</i>	18
<i>Account Collections and Delinquent Accounts</i>	19
<i>Delinquent Accounts</i>	19
<i>Failed Collections</i>	19
<i>Returned Check Policy</i>	19
<i>Refunds</i>	20
<i>Miscellaneous</i>	20
<i>Reporting</i>	21

Table of Figures

Figure 1 - Medicare Provider Fee Schedule 2013 RVU Files.....	4
Figure 2 - Download of current PFS file.....	5
Figure 3 - Medicare PFS RVU data files	5
Figure 4 - Medicare Carrier & Locality Codes by State/County	6
Figure 5- Medicare PFS RVU Fields for Use.....	6

Section 8 – Financial Policy

Figure 6 - WI GCPI Work, PE & MalPrac Values	7
Figure 7 - File Source for Fee Schedule Worksheet	8
Figure 8 - FAIR Organization's UCR estimator.....	10
Figure 9 - Sample Costs	14
Figure 10 - Sliding Fee Schedule example	16
Figure 11 - Federal Poverty Level 2013	17
Figure 12 - Payer Rates.....	21

Financial Policy

This section will give LHDs information to use in developing their own financial policies, including: how to set up a tracking database; understanding the Medicare fee schedule and use it to set their own rates; how to set up their own fee schedule; creating hardship sliding fee scales; and dealing with reporting and handling refunds.

Key Concepts:

- Developing and maintain charges
 - Create a maintenance database
 - Medicare physician fee schedule
 - Usual, reasonable, customary fees
 - Private vaccine charge
 - Administration fee
 - Medicaid
 - Medicare Part B
 - Medicare Part D
 - Sliding fee schedules
- Accounts Receivable & Collections
 - Residency requirements
 - Payment expectations
 - 3rd party billing expectations
 - Client payments
 - Collections
 - Delinquent accounts
 - Failed collections
 - Returned checks
 - Refunds
 - Reporting

Developing and maintaining charges

Create a Maintenance Database

Hospitals create “*chargemasters*” for tracking a myriad of items required for budgeting, reimbursement reconciliation, governmental cost reporting, etc. This is essentially a database of the calculations for all the services the hospital charges to patients. This is an excellent method for LHDs to use and can be managed with an Excel Workbook. Basic items to include would be:

- Unique identifier for each line
- General ledger number for the item
- Department number
- CPT/HCPCS code and NDC code, when applicable
- Modifier
- Code description
- Modifier description
- Charge amount

Section 8 – Financial Policy

Any statistical or reporting items unique to LHD
Allowable fee by payer
Status (active, no longer active)
Effective Date
End Date

Other worksheets can be created to handle formulas or calculations and updates to support the primary document. Additionally, collecting fee information from payer remittance advices, and adding them to this workbook, will give you both valuable information in negotiating fees. It will also assist those who collect copays or coinsurance at the time of service.

Medicare Physician Fee Schedule

Many physicians base their own charges on the annual Medicare National Physician Fee Schedule because CMS has already calculated the RVU's and geographic adjustments. Physicians typically set their charges anywhere from 100% - 300% of Medicare's fee. There are payers that also create their fee schedules based on the same logic.

Appendix 37 includes the fee schedule already calculated for Wisconsin, based on the Medicare 2013 National Physician Fee Schedule. LHDs can use the following steps to update their fee schedules when annual updates are released. It may seem confusing at first, but following the step-by-step instructions will help. The fee schedule only needs to be created once, and can be updated with new data annually, since immunization codes don't change often.

1. Go to <http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> and find the most recent RVU file (**Figure 1**). The first file of each calendar year ends with an "A", and subsequent releases (usually quarterly) end with consecutive letters. In this example, the newest file is *RVU13C*.

Calendar Year	File Name
2013	RVU13A
2013	RVU13AR
2013	RVU13B
2013	RVU13C
2012	RVU12A
2012	RVU12AR
2012	RVU12M

Figure 1 - Medicare Provider Fee Schedule 2013 RVU Files

2. Click on the Calendar Year hyperlink for the most recent file, as shown with an arrow in **Figure 1**.

Section 8 – Financial Policy



Figure 2 - Download of current PFS file

3. The previous action will take you to the download page and you will click on the zip file hyperlink, as outlined in **Figure 2**.
4. The zip file contains multiple versions of several files. You will want to use the Excel files containing “LOCCO”, “GPCI” and “PPRVU” in their names. These are marked with an arrow in **Figure 3** below.

Name	Type	Compressed size
13LOCCO.csv	Microsoft Excel Comma S...	2 KB
13LOCCO.txt	Text Document	2 KB
13LOCCO.xlsx	Microsoft Excel Worksheet	14 KB
ANES2013.csv	Microsoft Excel Comma S...	2 KB
ANES2013.txt	Text Document	2 KB
ANES2013.xlsx	Microsoft Excel Worksheet	13 KB
GPCI2013.csv	Microsoft Excel Comma S...	2 KB
GPCI2013.txt	Text Document	2 KB
GPCI2013.xlsx	Microsoft Excel Worksheet	14 KB
OPPSCAP_V0515.csv	Microsoft Excel Comma S...	150 KB
OPPSCAP_V0515.txt	Text Document	164 KB
OPPSCAP_V0515.xlsx	Microsoft Excel Worksheet	790 KB
PPRRVU13_V0503.txt	Text Document	344 KB
PPRRVU13_V0531.csv	Microsoft Excel Comma S...	299 KB
PPRRVU13_V0531.xlsx	Microsoft Excel Worksheet	1,599 KB
RVUPUF13.docx	Microsoft Word Document	126 KB

Figure 3 - Medicare PFS RVU data files

5. First open the file titled LOCCO (which stands for locality and county), and check that no Wisconsin counties have any special notes, but that it says “All Counties”, as in **Figure 4**. Medicare is statutorily required to adjust payments for physician fee schedule services to account for differences in costs due to geographic location. While none are shown in this figure, there are states that have larger populations and might have different Fee Schedule Areas, as well as multiple carriers. Once you have verified Wisconsin has a single locality, you can close out this file.

Section 8 – Financial Policy

Carrier Number	Locality Number	State	Fee Schedule Area	Counties
11402	16	WEST VIRGINIA	STATEWIDE	ALL COUNTIES
00951	00	WISCONSIN	STATEWIDE	ALL COUNTIES
03602	21	WYOMING	STATEWIDE	ALL COUNTIES

Figure 4 - Medicare Carrier & Locality Codes by State/County

- The next file to download is labeled as PPRVU (**Figure 3**), and this is usually the largest file in the zip set. Open this file, save it and rename as your fee schedule workbook. You can delete rows 1 through 8.

HCPCS	MOD	DESCRIPTION	STATUS CODE	MEDICARE PAYMENT	WORK RVU	NON-FAC PE RVU	NA INDICATOR	FACILITY PE RVU	FACILITY NA INDICATOR	MP RVU	NON-FACILITY TOTAL	FACILITY TOTAL	PCTC IND
A0021		Outside state ambulance serv	I		0.00	0.00		0.00			0.00	0.00	0.00
A0080		Noninterest escort in non er	I		0.00	0.00		0.00					
A0090		Interest escort in non er	I		0.00	0.00		0.00					
A0100		Nonemergency transport taxi	I		0.00	0.00		0.00					
A0110		Nonemergency transport bus	I		0.00	0.00		0.00					
A0120		Noner transport mini-bus	I		0.00	0.00		0.00					
A0130		Noner transport wheelch van	I		0.00	0.00		0.00					
A0140		Nonemergency transport air	I		0.00	0.00		0.00					
A0160		Noner transport case worker	I		0.00	0.00		0.00					
A0170		Transport parking fees/tolls	I		0.00	0.00		0.00					
A0180		Noner transport lodgng recip	I		0.00	0.00		0.00					
A0190		Noner transport meals recip	I		0.00	0.00		0.00					
A0200		Noner transport lodgng escrt	I		0.00	0.00		0.00					
A0210		Noner transport meals escort	I		0.00	0.00		0.00					

DESCRIPTION	STATUS CODE	NA	CU	U	W	X	Y	Z	CONV FACTOR
Outside state ambulance serv	I			9	9	9			31.0230 09
Noninterest escort in non er	I			9	9	9			31.0230 09
Interest escort in non er	I			9	9	9			31.0230 09
Nonemergency transport taxi	I			9	9	9			34.0230 09
Nonemergency transport bus	I			9	9	9			34.0230 09
Noner transport mini-bus	I			9	9	9			34.0230 09
Noner transport wheelch van	I			9	9	9			34.0230 09
Nonemergency transport air	I			9	9	9			34.0230 09

Figure 5- Medicare PFS RVU Fields for Use

FYI: The “Conv Fac” column (**Figure 5**) contains the Medicare conversion factor, which is updated on an annual basis according to a formula specified by statute. The formula¹ specifies that the annual update is equal to the Medicare Economic Index (MEI), adjusted based on the comparison of actual expenditures with a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in Fee-For-Service Medicare, and changes in law or regulation.

¹ Medicare Learning Network *PAYMENT SYSTEM FACT SHEET*

Section 8 – Financial Policy

7. Next, you will open the file titled GPCI (middle arrow in **Figure 3**). This contains the Geographic Practice Cost Indices² by state. These indices are measures of geographic differences. A GPCI of 1.2 indicates that practice expenses in that area are 20 percent above the national average, whereas a PE GPCI of 0.8 indicates that practice expenses in that area are 20 percent below the national average. CMS calculates the three GPICs for payment areas known as Medicare localities. Localities are defined alternatively by state boundaries (e.g., **Wisconsin**), metropolitan statistical areas (MSAs) (e.g., Metropolitan St. Louis, MO), portions of an MSA (e.g., Manhattan), or rest-of-state areas that exclude metropolitan areas (e.g., Rest of Missouri).

Unfortunately, there are no headers in this file, but the order of GPCI indices (**Figure 6**) after the column containing the name of the location is as follows:

- a. GPCI Work
- b. GPCI PE
- c. GPCI Malpractice

Make of note of these values and close the file. You are now finished with the zip file. Note that the GPCI values are only updated every three years, but you should still verify them just in case a regulation change would result in updates before the three year mark.

83	14502	50	Vermont	1.000	1.008	0.554
84	09202	50	Virgin Islands	1.000	1.002	1.010
85	11302	00	Virginia	1.000	0.977	0.731
86	02402	99	Rest of Washington	1.000	1.012	0.861
87	02402	02	Seattle (King Cnty), WA	1.025	1.144	0.881
88	11402	16	West Virginia	1.000	0.828	1.229
89	00951	00	Wisconsin	1.000	0.960	0.547
90	03602	21	Wyoming ***	1.000	1.000	1.255
91						

Figure 6 - WI GCPI Work, PE & MalPrac Values

8. Re-open the file you saved as your fee schedule workbook. You can delete rows 1-9. You need to do a few steps to finish the task:
- a. Insert new columns **after** the following columns:
 - i. column F which should be [Work] RVU
 - ii. column G or [Non-Fac] PE RVU
 - iii. column K or [MP] RVU
 - b. There are only seven columns that you will need to save as listed in **Figure 5** above. Delete all columns *except*:
 - i. HCPCS (column A)
 - ii. Description (column C)
 - iii. Status (if you want this code as it is Medicare status) (column D)
 - iv. Work RVU (column F)
 - v. Non-Fac PE RVU (column G)
 - vi. MP RVU (Column K)
 - vii. Conv Factor (column Y)
 - c. Rename the remaining columns as follows, beginning with column A:
 - i. Proc Code or Procedure Code
 - ii. Description
 - iii. Medicare Status (if you want to model after Medicare code) (column D)

² CMS report - *Geographic Adjustment of Medicare Payments to Physicians: Evaluation of IOM Recommendations*

Section 8 – Financial Policy

- iv. Work RVU
- v. CPCI Work
- vi. PE RVU *or* Practice Expense RVU
- vii. MalPrac RVU *or* Malpractice RVU
- viii. ConvFac (CF) or Conversion Factor
- ix. Calc'd RVU or Calculated RVU
- x. Medicare Allowable (Calc'd RVU * CF)
- d. Eliminate all non-immunization related codes.
 - i. Delete all the rows from the first code through D9999.
 - ii. Delete all the rows from code G0027 through code 89398
 - iii. Delete all the rows from code 90785 through code 99199
 - iv. Delete all the rows from code 99217 through code 99380
 - v. Delete all the rows from code 99406 through last row.
- e. Finally, populate the GPCI columns with the values you noted in step 9 above.

9. The modified worksheet will look like **Figure 7** with columns A – L and approximately 142 rows. You may eliminate any rows that represent vaccines you do not administer or office visits that you do not bill for to make the file even smaller.

	A	B	C	D	E	F	G	H	I	J	K	L
1	Proc Code	DESCRIPTION	MEDICARE Status	Work RVU	GPCI Work	PE RVU	GPCI PE	MalPrac RVU	GPCI MalPrac	ConvFac (CF)	CALC'D RVU	Medicare Allowable (CALC'D RVU * CF)
2	G0008	Admin influenza virus vac	X = statutory exclusion	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
3	G0009	Admin pneumococcal vaccine	X = statutory exclusion	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
4	G0010	Admin hepatitis b vaccine	X = statutory exclusion	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
5	90281	Human ig im	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
6	90283	Human ig iv	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
7	90284	Human ig sc	X = statutory exclusion	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
8	90287	Botulinum antitoxin	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
9	90288	Botulism ig iv	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
10	90291	Cmv ig iv	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
11	90296	Diphtheria antitoxin	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
12	90371	Hep b ig im	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
13	90375	Rabies ig im/sc	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
14	90376	Rabies ig heat treated	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
15	90378	Rsv mab im 50mg	X = statutory exclusion	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
16	90384	Rh ig full-dose im	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
17	90385	Rh ig minidose im	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
18	90386	Rh ig iv	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
19	90389	Tetanus ig im	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
20	90393	Vaccina ig im	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
21	90396	Varicella-zoster ig im	E = excluded by regs	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
22	90399	Immune globulin	I = not valid, Mcare uses other code	0.00	1.00	0.00	0.960	0.00	0.547	34.0230	0.0000	\$ -
23	90460	Im admin 1st/only component	A = active	0.17	1.00	0.58	0.960	0.01	0.547	34.0230	0.7323	\$ 24.91
24	90461	Im admin each addl component	A = active	0.15	1.00	0.21	0.960	0.01	0.547	34.0230	0.3571	\$ 12.15
25	90471	Immunization admin	A = active	0.17	1.00	0.58	0.960	0.01	0.547	34.0230	0.7323	\$ 24.91
26	90472	Immunization admin each add	A = active	0.15	1.00	0.21	0.960	0.01	0.547	34.0230	0.3571	\$ 12.15
27	90473	Immune admin oral/nasal	R = restrict coverage	0.17	1.00	0.58	0.960	0.01	0.547	34.0230	0.7323	\$ 24.91
28	90474	Immune admin oral/nasal addl	R = restrict coverage	0.15	1.00	0.21	0.960	0.01	0.547	34.0230	0.3571	\$ 12.15

Figure 7 - File Source for Fee Schedule Worksheet

10. You can now enter formulas to determine the calculated RVU and the Medicare Allowable.

- a. To create the Calculated RVU value:
 - i. Enter the following formula in cell K2:
 - 1. =SUM((D2*E2)+(F2*G2)+(H2*I2))
 - ii. Highlight and drag the formula down the column to the last row
- b. To calculate the Medicare Allowable:

Section 8 – Financial Policy

- i. Enter the following formula in cell L2:
 1. =SUM(J2*K2)
- ii. Highlight and drag the formula down the column to the last row

Where no Medicare allowable was calculated, it is either because Medicare doesn't cover the service (as in pediatric doses) or a usual/customary amount is develop by the carrier.

Usual and Reasonable or Customary Charges

Also known as U&C, UCR or U&R, this is the charge that is the average rate or charge for identical or similar services in a certain geographical area. Insurers will set these rates based on their own analysis of charges seen in their claims database or they may purchase access to a database such as one offered through AHIP or other organizations. There are other commercial sources if claims data, such as Ingenix.

The AMA defines *Usual, Customary and Reasonable* (UCR) as:

"Usual": the fee an individual physician usually charges his or her private patient for a given service (i.e., his or her own usual fee);

"Customary": a fee that is within the range of usual fees physicians of similar training and experience currently charge for the same service within the same specific and limited geographical area; and

"Reasonable": a fee that meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question without regard to payments that governmental or private plans have discounted.

There are sources for consumers to find out the cost of medical procedures (**Figure 8** is an example of FAIR Health's UCR estimator). In 2009, an investigation by the New York State Attorney General Andrew Cuomo uncovered conflicts of interest in one system that health insurers used to calculate reimbursement for patients who received care from providers outside their plan's network. As a result of this investigation, FAIR Health—an independent, not-for-profit corporation—was created to establish and maintain a new database that could be used to help insurers determine their reimbursement rates for out-of-network charges, and provide patients with a clear, unbiased explanation of the reimbursement process. This is located at <http://www.fairhealthconsumer.org/medicalcostlookup/cost.aspx>, but is limited to 20 lookups/week. This can be a helpful and free tool for an LHD to find what is considered UCR for specific immunization services in their zip code area(s).

Section 8 – Financial Policy



Figure 8 - FAIR Organization's UCR estimator

Components of Establishing Usual & Customary Rates (UCR)

Most³ methods for establishing usual and customary rates consist of identifying the total cost for a particular service coupled with establishing the quantity or amount of billing capacity that exists.

Cost information should include direct costs, support costs and administrative costs. Organizations may also include margin or profit as a factor of establishing rates when it does not conflict with other applicable accounting standards, OMB guidelines or regulation. Cost information may be based on historical accounting information, audited financial reports or projections for the current budget period.

Billable time is defined as face-to-face time with the client. Activity including preparation, report writing, record review, discussion with other professionals and no-shows should be considered as non-billable time. This non-billable time should be considered and built into the rate charged for face-to-face time.

$$\text{Usual \& Customary Rate} = \frac{\text{Cost}}{\text{Billable Activity}}$$

<u>Cost</u>	<u>Billable Activity</u>	<u>Non-Billable Activity Considered in rate</u>
Direct Staff Salary & Benefits Support Staff Salary & Benefits Facilities & Capital Improvements Vehicles Equipment Transportation Travel Cost	Face-to-Face Contact Service Coordination Assessment & Evaluation Immunization clinics	Travel to/from offsite clinic Report Writing Documentation Contact w/ Other Professionals Staff Meetings Administrative Activity Sick/Vacation Time

³ Indiana Children's Special Health Care Services document - *How to Establish Usual and Customary Rates*, pp. 3-4

Section 8 – Financial Policy

Materials & Supplies Utilities Insurance Miscellaneous Administrative Costs		Training
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Private Supply Vaccine Charge

The cost of privately purchased vaccine is based on the purchase price, plus any shipping, handling or taxes associated with the purchase of each vaccine. The CDC Price List (see **Appendix 38**) includes both their contracted rate and the “private sector cost/dose”.

To distinguish between state supplied vaccine and private stock, it is important to use the modifier below when billing for state supplied vaccine. No reimbursement will be made for the vaccine, and it will tell the payer why you are billing for an administration fee and prevent the claim from being pended for review. When billing for private stock, do not use the “SL” modifier.

SL	State supplied vaccine
-----------	------------------------

Administration Fee

According to AHIP⁴, “CPT codes for vaccine administration cover a wide range of costs associated with vaccine delivery, including:

- counseling,
- scheduling,
- preparing the patient chart,
- billing,
- greeting the patient,
- taking vital signs,
- obtaining a vaccine history,
- presenting Vaccine Information Sheets (VIS),
- preparing and administering the vaccine, and
- observing for adverse events.”

There following are the immunization administration codes as of summer, 2013:

Codes with counseling, ages 0 through 18:

90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; <i>each additional vaccine</i> or toxoid component administered (List separately in addition to code for primary procedure)

⁴ AHIP Vaccine Financing Roundtable Report

Section 8 – Financial Policy

Important Coding Note

These codes are reported for either single or combination vaccine administration *when the physician or other qualified health care professional provides counseling at the time of the administration.*

There is some controversy over whether or not an RN is allowed to use these codes, or any E/M code using the “other qualified healthcare professional” terminology. The rationale is that providers other than physicians—including nurse practitioners, physician assistants, and physical and occupational therapists—use these codes, but **not registered nurses, licensed practical nurses, or medical assistants.**

Although some CPT code descriptors (that is, critical care codes) were not revised to include the new terminology, the E/M section guidelines were modified to allow non-physician providers to report services.

If you are unsure whether a provider can use a specific E/M code, check the:

- state scope of practice,
- facility requirements,
- payer policies, and
- Medicare claims processing manual.

Codes without counseling, any age group, by route:

90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Codes for Medicare billing only:

G0008	Administration of influenza virus vaccine
G0010	Administration of pneumococcal vaccine
G0011	Administration of hepatitis B vaccine

An article in the American Academy of Pediatrics journal, “*Pediatrics*” by Glazner et al. (2007) titled *Cost of Vaccine Administration among Pediatric Practices* describes the variable costs of vaccine administration by providers. While the costs may be outdated, the methodology could be replicated by

Section 8 – Financial Policy

an LHD to establish administration fees. You can adapt the methods used in this study, portrayed below, for your LHD staff and immunizations.

“Participants

Ten private pediatric practices in the Denver, Colorado, metropolitan area participated in the study. The practices varied in urban/suburban location and in size, with 4 urban and 6 suburban practices. The number of physicians in the participating offices ranged from 3 to 8, with a median of 6. Six practices participated during August 2007 and 4 participated during October, November, and the first week of December. We included the 4 pediatric practices that had participated in the 2001 immunization administration study. The other practices were selected on the basis of their previous willingness to participate in other research studies conducted by Dr. Berman. In Colorado, practices are paid on a fee-for-service basis. Colorado is not a universal-purchase state.

Data Collection

We estimated pediatrician practice costs by using a micro-costing approach. This method involves individual measurement of resources used to provide a given medical service and is the method for estimation of costs preferred by the US Panel on Cost-effectiveness in Medicine.¹¹ By using this approach, we **collected time and cost data on every immunization-related activity performed by practice staff members, as well as the cost of immunization-related supplies. All staff members at participating practices completed time diaries for these activities for a minimum of 2 days, as long as data for ≥ 100 injections (or oral vaccine administrations) were recorded; this was required to achieve stability of time and cost estimates. Smaller practices kept diaries for 3 days to reach the threshold of 100 injections.** There were 4 different diaries for 4 distinct types of activities, that is, nursing, billing, using and updating the immunization registry, and non-routine activities such as vaccine inventory and ordering and answering telephone questions about vaccinations.

Immunization-Related Activities Recorded by Staff Members of Pediatric Practices in the Denver Metropolitan Area in 2007. Physicians were not asked to keep time diaries but were interviewed about the time they spent on immunization activities during a well-child visit, as well as immunization-related activities occurring outside the visit. Practice administrators also were interviewed and were asked to provide data on items such as the **monthly cost of waste disposal, whether the practice had bought a new refrigerator since the beginning of the vaccine schedule's expansion, and vaccine-ordering practices, in addition to the time they spent on immunization activities.**

After all data were collected and verified, we **completed a spreadsheet for all staff members for each practice for all activities in the major categories (i.e., nursing, billing, registry use, non-routine activities, and physician activities). We recorded the time spent on each activity and the job title of the staff member who performed the activity for each practice. To convert the time to cost, we used median salaries for the Denver metropolitan area for each job class (e.g., receptionist, medical assistant, pediatrician, registered nurse, and billing clerk), as provided by the Bureau of Labor Statistics.** We calculated benefits on the basis of benefit percentages for each job class.

To calculate practice time and costs associated with vaccination administration, **we averaged the time reported for each major activity across all practices. We then calculated an average**

Section 8 – Financial Policy

cost per injection by dividing the cost of each category across all practices by the total number of injections administered by all practices. This method takes into account any cost savings associated with administering multiple injections. It also allows the combined variable costs of multiple injections to be compared with the sum of vaccine administration payments for the initial and additional immunizations.

Variable Cost Measurement

Variable costs are those that vary with the amount of production, in this case, administration of vaccinations. **Variable costs are those used in decision-making about whether to provide the service or to produce the product. Fixed costs (e.g., rent and malpractice insurance) typically are not included in such decision-making because they do not change whether vaccinations are provided or not.** If, by administering vaccinations, a practice can cover its variable costs and contribute something to fixed costs (i.e., payments exceed variable costs), then the reasonable decision would be to deliver vaccinations. We also included supply costs and medical waste-disposal costs. **Variable costs are expressed throughout the report as cost per injection (or oral administration).** This analytic unit is used rather than antigen because there are combination vaccinations.

In addition to measuring **variable costs**, we took into account several other costs, including the **cost of any new equipment and other expenditures such as vaccine insurance necessitated by the fact that more vaccines must be kept in stock.** Refrigerators, generators, and other equipment usually are treated as fixed costs; however, because we wanted to portray all costs associated with the expansion of the immunization schedule, we collected data on the cost of those items (**Figure 9**).”

Category	Time per Injection, min	Cost per Injection, Mean, \$
Personnel		
Nursing	3.87	1.71
Billing	5.23	2.67
Nonroutine ^a	3.78	1.64
Registry	2.11	0.96
Physician	2.62	4.05
Total for personnel	17.61	11.03
Supplies		
Syringe and needles		0.36
Medical waste disposal		0.12
Total variable costs		11.51

^aNonroutine activities primarily include performing vaccine inventory and ordering, providing vaccination records to requesters, and answering parent telephone questions about vaccinations.

Figure 9 - Sample Costs

(Adapted from Table 2 in the article by Glazner et al. referenced above.)

Section 8 – Financial Policy

Medicaid Administration Fee

Immunizations for Members 19 Years of Age or Older

For vaccines from a provider's private stock that are administered to members 19 years of age or older, ForwardHealth **reimburses for the vaccine and the administration fee.**

HealthCheck

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so **providers should not separately bill the administration code.** Providers are required to indicate their usual and customary charge for the service with the procedure code.

VFC (See Topic 503 – Immunizations)

Vaccines recommended for members 18 years of age or younger are available through the federal VFC Program at no cost to the provider. ForwardHealth **reimburses only the administration fee** for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from a private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

For the VFC program, an initial Federal Register notice, setting forth the interim maximum amounts a participating provider may charge for administering a vaccine to a VFC child, was published on October 3, 1994. The administration fees were established on the basis of national charge data that were obtained under a Federal contract with the American Academy of Pediatrics. Charge data was used rather than cost data, because accurate, useable nationwide cost data was not available, nor could be obtained by CMS by October 1, 1994. See **Appendix 39.**

Medicare Part B Administration Fee

The allowed amount for the administration of the influenza and pneumococcal vaccines is based on the same rate as the HCPCS code 90471 (Immunization Administration, Hepatitis B Virus (HBV) Vaccine) as priced on the physician fee schedule database. When billing Medicare, providers will submit the code G0008 (influenza) or G0009 (pneumococcal) for the administration of vaccine. Therefore, the allowable fee for the administration of the seasonal influenza and/or pneumococcal vaccines will vary based on the locality of the provider.

The following codes are used to bill administration fees under Medicare Part B.

- G0008 – Administration of influenza virus vaccine
- G0009 – Administration of pneumococcal vaccine
- G0010 – Administration of Hepatitis B vaccine
- G9141 – Administration of Influenza A (H1N1) vaccine

Medicare Part D Administration Fee

A member can get these immunizations at a pharmacy for his or her Part D prescription drug benefit copay. At a provider's office, the member owes 100% of the cost of the vaccine and administration. **Vaccine administration services are not reimbursed** by the Medicare Part D program.

Section 8 – Financial Policy

Sliding Fee Schedules

In most states (except California) it is illegal to bill insurance companies more than for an uninsured patient. However, because of the mission of the LHD, sliding fee schedules are generally set up, based on federal poverty guidelines, for those with an inability to pay the full amount or who are uninsured. **Figure 10** is an example of one used in Kern County, CA from the California Immunization Billing Project Final Plan document⁵. In the plan, the Services are set up in the left hand column using CPT codes with the short description. The next column is Kern County LHD’s Usual Charge (based on actual cost and 3rd party reimbursements). The next columns are based on what their office decided as the discount off U&C based on the poverty guidelines for that year. As you can see, families in the “D” row (100%) of the poverty guideline must pay the full fee, there is a discount applied at the 50% and 30% levels and a final minimum payment. For those paying cash for immunization services, Kern County set the cost at a \$13 administration fee, with a maximum of \$40 per family.

Determine family size then choose the income amount that corresponds to the number of people living in the household. The letter to the left of that box determines the fee for a routine or extended exam.					
Clinic Services	Usual Charge*	Proposed Fees			
		A = Min	B = 30%	C = 50%	D = 100%
99201 New Patient/Initial/10 Minutes	\$79.00	\$13.00	\$24.00	\$39.00	\$79.00
99202 New Patient/Initial/20 Minutes	\$98.00	\$13.00	\$29.00	\$49.00	\$98.00
99203 New Patient/Initial/30 Minutes	\$128.00	\$13.00	\$38.00	\$64.00	\$128.00
99204 New Patient/Initial/45 Minutes	\$183.00	\$13.00	\$55.00	\$91.00	\$183.00
99211 Established Patient/5 Minutes	\$45.00	\$13.00	\$14.00	\$22.00	\$45.00
99212 Established Patient/10 Minutes	\$64.00	\$13.00	\$19.00	\$32.00	\$64.00
99213 Established Patient/15 Minutes	\$82.00	\$13.00	\$25.00	\$41.00	\$82.00
99214 Established Patient/ Comprehensive/ 25 Minutes	\$119.00	\$13.00	\$36.00	\$60.00	\$119.00

* Usual Charge is based on actual costs and 3rd party reimbursable rates allowed.

Poverty Guidelines 2010								
Family Members Income Monthly Max for Sliding Fee Scale								
Family Size →	1	2	3	4	5	6	7	8
A	\$0- \$1,083.00	\$0- \$1,457.00	\$0- \$1,831.00	\$0- \$2,205.00	\$0- \$2,579.00	\$0- \$2,953.00	\$0- \$3,327.00	\$0- \$3,701.00
B	\$1,353.75	\$1,821.25	\$2,288.75	\$2,756.25	\$3,223.75	\$3,691.25	\$4,158.75	\$4,626.25
C	\$1,669.63	\$2,246.21	\$2,822.79	\$3,399.38	\$3,975.96	\$4,552.54	\$5,129.13	\$5,705.71
D	\$2,256.25	\$3,035.42	\$3,814.58	\$4,593.75	\$5,372.92	\$6,152.08	\$6,931.25	\$7,710.42

Figure 10 - Sliding Fee Schedule example

Figure 11 includes the current (2013) poverty guidelines to use in developing your own sliding fee schedule. These guidelines are updated annually and can be found on numerous government websites including: Medicaid.gov, Familiesusa.org (<http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html>) – which has breakdowns of up to 400%, and Wisconsin DHS (<http://www.dhs.wisconsin.gov/medicaid/fpl/fpl.htm>), going up to 300%.

⁵ http://psbweb.co.kern.ca.us/PH_Internet/pdfs/HotTopic/FinalCaliforniaBillingPlan.pdf

Section 8 – Financial Policy

2013 POVERTY GUIDELINES ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	11,490.00	13,788.00	15,281.70	15,511.50	17,235.00	20,107.50	21,256.50	22,980.00	28,725.00
2	15,510.00	18,612.00	20,628.30	20,938.50	23,265.00	27,142.50	28,693.50	31,020.00	38,775.00
3	19,530.00	23,436.00	25,974.90	26,365.50	29,295.00	34,177.50	36,130.50	39,060.00	48,825.00
4	23,550.00	28,260.00	31,321.50	31,792.50	35,325.00	41,212.50	43,567.50	47,100.00	58,875.00
5	27,570.00	33,084.00	36,668.10	37,219.50	41,355.00	48,247.50	51,004.50	55,140.00	68,925.00
6	31,590.00	37,908.00	42,014.70	42,646.50	47,385.00	55,282.50	58,441.50	63,180.00	78,975.00
7	35,610.00	42,732.00	47,361.30	48,073.50	53,415.00	62,317.50	65,878.50	71,220.00	89,025.00
8	39,630.00	47,556.00	52,707.90	53,500.50	59,445.00	69,352.50	73,315.50	79,260.00	99,075.00

For family units of more than 8 members, add \$4,020 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	957.50	1,149.00	1,273.48	1,292.63	1,436.25	1,675.63	1,771.38	1,915.00	2,393.75
2	1,292.50	1,551.00	1,719.03	1,744.88	1,938.75	2,261.88	2,391.13	2,585.00	3,231.25
3	1,627.50	1,953.00	2,164.58	2,197.13	2,441.25	2,848.13	3,010.88	3,255.00	4,068.75
4	1,962.50	2,355.00	2,610.13	2,649.38	2,943.75	3,434.38	3,630.63	3,925.00	4,906.25
5	2,297.50	2,757.00	3,055.68	3,101.63	3,446.25	4,020.63	4,250.38	4,595.00	5,743.75
6	2,632.50	3,159.00	3,501.23	3,553.88	3,948.75	4,606.88	4,870.13	5,265.00	6,581.25
7	2,967.50	3,561.00	3,946.78	4,006.13	4,451.25	5,193.13	5,489.88	5,935.00	7,418.75
8	3,302.50	3,963.00	4,392.33	4,458.38	4,953.75	5,779.38	6,109.63	6,605.00	8,256.25

Produced by: CMCS/CAHPG/DEEO

Figure 11 - Federal Poverty Level 2013

Appendix 40 is an example of an office form for sliding fee schedule use.

Accounts Receivable and Collections

Now that you are billing private payers, Medicare and/or Medicaid, you will need to establish a policy and procedure (P&P) to assist in following up on the payments or denials, and log and track your data for future reference and negotiations. A P&P manual also helps you enforce guidelines.

Items you might want to consider putting in such a manual:

Residency Requirements

Do you have residency requirements for services? If so, they should be clearly defined to support any future collection issues. Examples might be:

- Proof of County residency is required for all new clients and at the yearly income assessment review.
- Clients are required to report any change of address.
- Documentation of residency may include:
 - government-issued ID (such as a driver's license)
 - utility receipt
 - rent or mortgage statement
 - Collateral Statement completed by a non-relative

Section 8 – Financial Policy

- We may make exceptions about documentation for homeless individuals who reside in County.
- Clients who move out of County have 30 days to obtain another provider. During these 30 days, they may continue to receive services at the LHD.

Fee and Payment Expectations

- All fees are the responsibility of the client or responsible party.
- Full payment is expected at the time of service.
- If you accept major credit or debit cards list those.
- Clients will be informed of their account status at each visit.
- Itemized receipts will be provided at time of payment.
- If you will allow a payment plan – define criteria and create forms to support this policy.
- Define methodology used to create U&C, other fees and sliding fee schedules.

Third Party Billing Expectations

- List the payers with whom you have a contract or are a participating provider; be sure to include Medicare (Parts C, B and/or D), MA HMO's and BadgerCare.
- A statement often seen in such a policy may be included: *“As a courtesy to clients, we may bill non-participating third party payers for medical services provided. The client is ultimately responsible for any uncovered charges.”*
- Will you bill secondary insurers, or will you provide an itemized statement and have the client submit the claim? The latter will mean that you must collect the balance due from the patient.
- Be sure that clients who have health insurance show a valid insurance card when they come for their immunization appointment.
- A determination will be made to see if a client is eligible for Medicaid.
- Clients must present all social security numbers and names they have used for employment purposes.
- Social security number and name will be used *by authorized staff only* for online income verification.

Client Payment Expectations

- The client pays any insurance co-pay amounts **at the time of service(s)**.
- It should be noted that Wisconsin law prohibits reducing or waiving of the patient's cost-sharing amounts if they are insured:
 - **WI 146.905 Reduction in fees prohibited.**
Except as provided in sub. (2), a health care provider, as defined in s. 146.81 (1) (a) to (p), that provides a service or a product to an individual with coverage under a disability insurance policy, as defined in s. 632.895 (1) (a), **may not reduce or eliminate or offer to reduce or eliminate coinsurance or a deductible required** under the terms of the disability insurance policy.
Subsection (1) does not apply if payment of the total fee would impose an undue financial hardship on the individual receiving the service or product.
- The policy should indicate when a client can expect to be billed – do you bill on a monthly or basis – and that they will be informed of the policy at time of service.

Section 8 – Financial Policy

Account Collections and Delinquent Accounts

- Clients are expected to make payment at the time they receive services, and/or to provide up-to-date information about their 3rd party insurance, Medicare or Medicaid coverage.
- If payment for service is not made in full on the date of service, the LHD may use the following methods to pursue collection of client accounts:
 - billing statements,
 - past due notices,
 - collection agencies or credit bureaus,
 - or any other method your office uses.

Delinquent Accounts

- Define what is considered a delinquent account. Is it if a payment balance is still due **60, 90,** or **120** days after the charge activity or after the most recent payment made (whichever is later)?
- Define how delinquent accounts are handled. Does it go through a city/county office or process? If so, define that process or reference where it can be found.
- What are the consequences of a delinquent account?
 - 1) Unless state and federal program rules prohibit restricting or denying services, persons who have a delinquent account *may* be:
 - required to pay fees before they can get more services, or
 - denied services, unless they make a good faith effort to make payment within 90 days. (*Note:* These are examples. Use your LHD rules.)
 - 2) Medicaid coverage will not be denied services because of an unpaid account balance.

Failed Collections

When are accounts considered to be bad debts, and how are they handled?

- The LHD reviews accounts each year for bad debt status. If no further collection is anticipated, the Business Officer will decide if there are amounts to be written off as bad debt, for accounting purposes only.
- Debts written off are still subject to collection.
- Will a client be notified that the account has been written off as a bad debt?
- If a debt is written off for accounting purposes, and later a payment is received, this payment is accepted and properly credited to the client's account.

Returned Check Policy

If you allow personal checks for payment, you need to have a policy on how to handle checks returned for insufficient funds. Here is an example below.

If a client's check is returned:

- We will notify the client by telephone, if possible.
- If a telephone number is not available, we will mail a notice.
- We will inform and give the client a copy of LHD or County's Returned Check Policy.
- The client must replace all returned checks with cash, money order, and/or certified check. We charge an additional \$XX.00 fee per returned check.
- If a client has two returned checks within a one-year period, they will have to pay for services using cash, money order, and/or certified check for a period of one year.
- After the one-year period expires, if another returned check occurs, the client must pay all future bills with cash, money order, and/or certified check.

Section 8 – Financial Policy

Refunds

What is your policy regarding refunds, and is it different if the overpayment was made by the client or other third-party payer? Do you:

- 1) apply the credit to future charges, or
- 2) refund the amount within thirty (30) days of discovery or request.

Do you handle each service or date of service singularly, or do you have an aggregate account for each client? If you use an aggregate system, you might find that a credit for one service doesn't mean the account in full has a credit. In this case, you will want to make your policy clear, since you might only be providing a refund once the entire account is paid in full and then a credit remains. There are some providers who use this method; although it is not payer friendly.

Miscellaneous

Do you have any other fees or policies that need to be documented?

- Do you charge for making record copies? Create an easy to read table of the charge for different numbers of pages and include it.

#Pgs.	Charge	#Pgs.	Charge
1	\$ 0.75	40	\$ 26.25
2	\$ 1.50	41	\$ 26.75
3	\$ 2.25	42	\$ 27.25
4	\$ 3.00	43	\$ 27.75
5	\$ 3.75	44	\$ 28.25
6	\$ 4.50	45	\$ 28.75
7	\$ 5.25	46	\$ 29.25
8	\$ 6.00	47	\$ 29.75
9	\$ 6.75	48	\$ 30.25
10	\$ 7.50	49	\$ 30.75
11	\$ 8.25	50	\$ 31.25
12	\$ 9.00	51	\$ 31.75
13	\$ 9.75	52	\$ 32.25
14	\$ 10.50	53	\$ 32.75
15	\$ 11.25	54	\$ 33.25
16	\$ 12.00	55	\$ 33.75
17	\$ 12.75	56	\$ 34.25
18	\$ 13.50	57	\$ 34.75
19	\$ 14.25	58	\$ 35.25
20	\$ 15.00	59	\$ 35.75
21	\$ 15.75	60	\$ 36.25
22	\$ 16.50	61	\$ 36.75
23	\$ 17.25	62	\$ 37.25
24	\$ 18.00	63	\$ 37.75
25	\$ 18.75	64	\$ 38.25
26	\$ 19.25	65	\$ 38.75
27	\$ 19.75	66	\$ 39.25
28	\$ 20.25	67	\$ 39.75
29	\$ 20.75	68	\$ 40.25
30	\$ 21.25	69	\$ 40.75
31	\$ 21.75	70	\$ 41.25
32	\$ 22.25	71	\$ 41.75
33	\$ 22.75	72	\$ 42.25
34	\$ 23.25	73	\$ 42.75
35	\$ 23.75	74	\$ 43.25
36	\$ 24.25	75	\$ 43.75

Section 8 – Financial Policy

#Pgs.	Charge	#Pgs.	Charge

Reporting

Set up a simple database (e.g., using Excel) to track the critical information you will need to analyze your payments going forward.

One spreadsheet can be a collection of the allowable fees you are seeing from your payers. **Figure 12** is a good example of a report. Take a listing of all the immunization procedure codes that you use (copy from **Appendix 41** to Excel) and list your charges for each in Column C. In the next columns, enter the payers you are receiving reimbursement from – you may find that you need to have multiples for each payer (for instance, you might have a Dean HMO, a Dean MA HMO and a Dean PPO that all reimburse at a different rate). As you receive payments, or on a regular basis, enter the *allowed* amounts (from the RA or EOB). In the Average of All Payers column, use the formula “=AVERAGE(D3:L3)” and copy it down the column. This will be your prevailing fee information for the next year or when you renegotiate. You will also be able to see which payer is giving you better reimbursement by service.

1	A	B	C	D									M
2	Proc Code	DESCRIPTION	Charge	Reimbursement/Payer									Average All Payers
				Payer 1	Payer 2	Payer 3	Payer 4	Payer 5	Medicaid	Mcare Adv	Medicare B	Medicare D	
3	G0008	Admin influenza virus vac	\$ 20.00	\$ 11.75	\$ 15.00	\$ 15.00	\$ 13.75	\$ 12.00	\$ -	\$ 14.00	\$ 15.00	\$ 16.00	\$ 12.50
4	G0009	Admin pneumococcal vaccine	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	G0010	Admin hepatitis b vaccine	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	90281	Human ig im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7	90283	Human ig iv	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8	90284	Human ig sc	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	90287	Botulinum antitoxin	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	90288	Botulism ig iv	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11	90291	Cmv ig iv	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12	90296	Diphtheria antitoxin	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13	90371	Hep b ig im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14	90375	Rabies ig im/sc	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15	90376	Rabies ig heat treated	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16	90378	Rsv mab im 50mg	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
17	90384	Rh ig full-dose im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18	90385	Rh ig minidose im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19	90386	Rh ig iv	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20	90389	Tetanus ig im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
21	90393	Vaccina ig im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22	90396	Varicella-zoster ig im	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23	90399	Immune globulin	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24	90460	Im admin 1st/only component	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25	90461	Im admin each addl component	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26	90471	Immunization admin	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
27	90472	Immunization admin each add	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Figure 12 - Payer Rates

This is a safety net that you should always have in place because it will let you know when claims are being reimbursed at 100% of your billed charges. If you are being reimbursed at this level it is possible you are charging too little for the service. At the annual review of your schedule, you should determine if you are calculating a sufficient value for the service.

