Chapter 3

Covered Services

This chapter covers the services for which hospitals may receive reimbursement through the Health Care Responsibility Act (HCRA). HCRA reimburses out-of-county hospitals for inpatient and outpatient emergency services. HCRA may also reimburse out-of- county hospitals for elective/non-emergency services, provided the services are not available in the county of residence and there is a prior agreement with the county of residence to treat the patient.

All counties must notify the Agency of its decision to provide in- county reimbursement starting with the county fiscal year 1999- 2000. Any changes to its decision must be filed with the Agency along with copies of notifications to the affected in-county hospitals no later than 45 days following the start of the new county fiscal year in which the change takes effect (on or around November 14).

All HCRA funds, whether in-county or out-of-county, are only to be used to reimburse hospitals for qualified indigent emergency or pre-approved non-emergency care. Please refer to Section 3-15, page 3-9, for services and care NOT covered by HCRA.

Additional information on non-emergency services is printed in Section 3-5. The policies regarding covered services used in HCRA are based on Rules 59G-4.150 and 59G-4.160, Florida Administrative Code (F.A.C.), and the Medicaid inpatient and outpatient covered services policy. Diagnoses or procedures not covered by Medicaid are also not covered through HCRA.

Emergency Care

3-1 Emergency Inpatient and Outpatient Services: An "emergency medical" condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

A. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus;

B. Serious impairment to bodily functions;

C. Serious dysfunction of any bodily organ or part;

D. With respect to a pregnant woman:

    1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Or:

The needed care and services were not available in the person's county of residence. Needed care and services are considered not available within the county of residence if a hospital within the county of residence transfers an indigent patient to an out-of- county hospital because the in-county hospital did not have the necessary treatment resources, such as diagnostic equipment or on- duty physicians, available.

Note: A physician must certify for each recipient that emergency services in a hospital are needed. The certification must be made at the time of admission. Upon request by the county of residence, the hospital will provide appropriate documentation to substantiate the emergency treatment.

3-2 Emergency Services and Ability to Pay: "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a participating or referral hospital. Emergency inpatient and outpatient services must be provided by the hospital without questioning the patient or any other person as to the ability to pay.

A. In the emergency room admission process, the hospital may take financial information as long as the diagnosis and treatment has commenced.

B. Likewise, in a patient transfer, a receiving hospital may not request a guarantee of payment from the transferring hospital as a condition of receiving the patient.

C. Hospitals not having an organized emergency department must determine whether an emergency medical condition exists, provide treatment, and assist persons seeking emergency care in obtaining necessary services.

3-3 Emergency Hysterectomies: Emergency hysterectomies are covered through HCRA provided the physician who performs the hysterectomy certifies that it was performed under a life threatening emergency situation in which prior acknowledgement was not possible. The certification must include a description of the nature of the emergency and the hospital must attach the physician's certification to the UB-04 claim form.

3-4 Abortions: HCRA pays for abortions and related procedures only if the life of the mother would be endangered if the fetus were carried to term. In such cases the hospital must provide a written physician's certification to the county, that based on his professional judgment, the abortion was necessary because of danger to the life of the mother. Without this documentation, the county must deny the claim.

A. The written statement must contain the name and address of the recipient.

B. The statement must be signed by the physician.

C. The hospital must attach this statement to the UB-92 claim form sent to the county for payment.

Non-Emergency Services

3-5 Elective and Non-Emergency Services: No county shall be required to pay for elective or non-emergency admissions or services at an out-of-county hospital for a qualified indigent when one of the following conditions exist:

A. If the county of residence provides funding for such services and the services are available at a hospital located within the resident county; or

B. The out-of-county hospital has not obtained prior written authorization and approval for such hospital admission or service, provided that the resident county has established written procedures to authorize and approve such admissions or services.

Any such pre-authorization and pre-approval procedures must be filed with the Agency. Such procedures must include requirements for out-of-county hospitals to request and obtain written authorization and approval for elective and non-emergency services and admissions.

For in-county hospitals, the applicant must be a resident of the county where the hospital is located and services were provided and the county must have elected to reimburse its in-county hospitals. All in-county HCRA applicants must meet the same HCRA eligibility requirements used for out-of-county eligibility determination. If the county has established less restrictive requirements, the applicant would be required to meet the county's requirements on file with the Agency. The HCRA would not apply to persons active with a county medical assistance plan if the treating hospital is a participating facility under the county's medical assistance plan. The HCRA is the payor of last resort.

3-6 Covered Oral Surgery: Hospitals may receive reimbursement for inpatient hospital care for a medically necessary admission for an oral surgery procedure. Elective dental procedures are reimbursable only if there is a prior written approval made with the county of residence.

3-7 Sterilization: As an elective or non-emergency procedure, sterilization is voluntary on the part of the recipient and is covered through HCRA only if the procedure is not available in the county of residence, the county chooses to pay for such services, **and** ALL of the following circumstances are true:

A. The patient was at least 21 years old at the time of signing a Florida Medicaid Sterilization Consent Form (see the Florida Medicaid Provider Reimbursement Handbook, UB-04, for a sample of the Sterilization Consent Form and the instructions on how to complete it);

B. The patient was mentally competent and not institutionalized in a correctional, penal, or rehabilitative facility, including a mental hospital or any other facility for the care and treatment of mental illness;

C. The Sterilization Consent Form was correctly completed at least 30 days prior to sterilization. The consent is valid for 180 days from the date the consent form was signed by the patient. Consent cannot be obtained during labor, childbirth, abortion, or under the influence of alcohol or other substances that affect the patient's state of awareness;

D. When premature delivery is marked on the Sterilization Consent Form, the expected date of delivery must be entered. There must have been at least 30 days between the expected date of delivery and the date the Sterilization Consent Form is signed. If premature delivery or emergency abdominal surgery occurs between 72 hours and 30 days after the consent signature, an exception is allowed;

E. The sterilization consent form must have been attached to the UB-04 claim form. HCRA will not pay for a sterilization without the completed consent form; and

F. The physician's statement on the consent form must be signed and dated by the physician who performed the sterilization on the date of the sterilization or after the sterilization procedure was performed. The date of service on the sterilization claim form must be identical to the date and type of operation which are given in the physician's statement on the consent form.

3-8 Organ Transplants: HCRA covers specific organ transplants, such as kidney, heart, cornea, liver, lung, and bone marrow transplants that are medically necessary. Refer to the Medicaid Hospital Services Coverage and Limitations Handbook. Prior authorization is required for all transplants except cornea transplants. Transplants are not considered emergency procedures. All transplant procedures must be covered within the 45-day inpatient cap per recipient per fiscal year and are restricted to the hospital reimbursement rate. All transplants, except cornea, must be performed at approved Agency designated Organ Transplant Programs in Florida to be paid through HCRA.

A. Approved Organ Transplant Programs may be found using Florida Health Finder at: http://www.floridahealthfinder.gov/FacilityLocator/FacilitySearch.aspx.

B. Each approved transplant center has a Clinical Review Board, which may also be referred to as the evaluation team. This Board is responsible for the following:

   1. Evaluating the transplant candidate, and

   2. Determining whether or not a recipient is a suitable candidate for a transplant.

C. To request prior authorization for an organ transplant procedure, the hospital must follow these steps:

   1. Verify that the county has chosen to establish procedures to authorize and approve admissions for such non-emergency services.

   2. Make sure the particular transplant is covered by HCRA.

   3. Attach a copy of the transplant evaluation performed by the Clinical Review Board.

   4. Send the prior authorization request to the county for medical review and approval.

If the county chooses to reimburse hospitals for transplant procedures, the county must review the request and verify medical necessity. The county must notify the hospital and patient if the reimbursement is approved or denied. If the county does not have access to medical staff to verify the necessity of the transplant, it may send the prior authorization request and documentation to the PDMM office at the address provided in Chapter 1, Section 1- 10, for review.

3-9 Hysterectomies: HCRA may pay for hysterectomies if they are not performed for the purpose of rendering a recipient permanently sterile, incapable of reproducing. These require prior authorization from the county. Other hysterectomy procedures are non- elective. HCRA may pay these if the county has established a procedure to authorize such admissions, if the procedure is not available in the county of residence, and if one of the following conditions is met:

A. The person who obtained authorization to perform the hysterectomy has informed the recipient and her representative, if any, orally and in writing, that the procedure will make her incapable of reproducing. She or her representative, if any, must have signed a written acknowledgement of receipt of that information.

B. The physician who performs the hysterectomy has certified that the individual was sterile at the time of the hysterectomy. On the same form, he must also state the cause of sterility.

Inpatient Care

3-10 Definition of Inpatient: An inpatient is a person who has received inpatient hospital services for a period of 24 hours or longer or with the expectation that they will receive inpatient hospital services for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

A. Such a patient is considered an inpatient even if he can be discharged or transferred to another hospital within his county of residence in less than 24 hours and does not actually use a hospital bed overnight.

B. HCRA inpatient reimbursement is limited to those eligible recipients who have been certified by a hospital utilization review committee as requiring inpatient hospital services.

3-11 Inpatient Covered Services Included in the Inpatient Reimbursement Rate: The following inpatient services are covered by HCRA within the reimbursement rate:

A. Supplies, appliances, and equipment ordinarily furnished by the hospital for the care and treatment of the patient during his inpatient stay. The patient may take such items with him upon discharge only if they are attached to his body and are necessary to facilitate his release from the hospital.

B. A bed in a semiprivate room (two to four beds in a room). Services shall be all inclusive. A private room shall be provided as part of the all inclusive service when ordered as a medical necessity by the attending physician.

C. Drugs and biologicals for use in a hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients.

D. Nursing and other related services, use of hospital facilities, and medical and social services ordinarily furnished by the hospital for inpatient treatment.

E. The first three pints of blood, if provided within the inpatient setting, are included in the per diem rate.

F. Diagnostic and therapeutic services as indicated in Rule 59G-4.150, F.A.C.

Outpatient Care

3-12 Outpatient Services: Outpatient hospital services are medically necessary, preventative, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to an outpatient, by or under the direction of a physician or dentist, by an institution that is licensed as a hospital. Emergency outpatient services are covered under HCRA. Elective outpatient services are covered only if the county has established a procedure to reimburse such services as indicated in Section 3-5 of this Chapter.

3-13 Definition of Outpatient: An outpatient is a person who has not been formally admitted by the hospital for the purpose of receiving inpatient hospital services. If the hospital uses the category "day patient" to describe an individual who receives the hospital services during the day and is not expected to be lodged in the facility for more than 24 hours, then the individual is classified as an outpatient.

When a patient with a known diagnosis is admitted to a hospital for a specific minor surgical procedure or other treatment that is expected to keep the patient in the hospital for less than 24 hours, he is considered an outpatient regardless of the hour of admission, whether or not he used a bed, and whether or not he remained in the hospital past midnight.

3-14 Outpatients Subsequently Admitted as Inpatients: Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. In such situations, the hospital may be eligible for reimbursement of services as follows:

A. If a patient is admitted to the hospital as an inpatient on the same day he received outpatient services, the hospital would bill the county for inpatient services, indicating the inpatient admit date as the date he received the outpatient services.

B. If a patient is admitted as an inpatient before midnight of the day following the day he received outpatient services, the inpatient admit date is the date he is admitted as an inpatient. The outpatient services are then considered part of the inpatient hospital stay.

Limitations

3-15 Days of Care and Items Not Covered by HCRA: The following items and days of care are not reimbursable through HCRA.

A. All inpatient hospital days not certified as medically necessary.

B. The patient's date of discharge from the hospital. The only exception is for an admission and discharge on the same day, which is reimbursable as one unit.

C. Inpatient hospital days beyond the discharge checkout time for a patient who chooses to occupy hospital accommodations beyond that date.

D. Administrative or grace days, or for leaves of absence by the hospital inpatient.

E. Late discharge penalty charges.

F. Physician services at the hospital (or elsewhere).

G. Items not directly related to the treatment and care of an illness or injury, such as rental television, massage, haircuts, guest trays, and guest beds.

H. Supplies, appliances and equipment furnished to an inpatient for use ONLY outside the hospital.

I. Cosmetic surgery performed only for aesthetic purposes.

J. Services of private duty nurses.

K. Blood replacement fee.

L. Items or services which are provided at no expense to the recipient.

M. Revenue center codes NOT listed in Appendices O and P.

3-16 Reimbursement Limitations: The county must reimburse participating hospitals through HCRA for up to a maximum of 45 days of inpatient services and up to $1,500 of emergency outpatient hospital services per eligible recipient per county fiscal year. Emergency outpatient services are reimbursable on a line-item Medicaid per diem rate. Reimbursement is covered further in Chapter 6.

The maximum amount of HCRA funds that a county can allocate for in-county reimbursement is up to ½ of its total HCRA funds, i.e., if a county must designate $500,000 for the fiscal year, it can only use a maximum of $250,000 for in-county hospital reimbursements. No county has the statutory authority to use out- of-county designated funds to supplement its in-county reimbursement amount above the aforementioned one half. Should a county exceed its designated in-county reimbursement limit, the additional funds must be provided through other funding sources from the county's budget and the amount exceeded shall not reduce the out-of-county obligation.

3-17 Exceptions to the $1,500 Reimbursement Limit: The county may authorize exceptions to the $1,500 outpatient reimbursement limit for certain surgical or medical procedures.

Chapter 4

Application Process

This chapter covers the application process pertaining to the Health Care Responsibility Act (HCRA). It covers the hospital's responsibilities regarding application processing as well as going step-by-step through the application. This chapter also covers the information the hospital will need to provide the county for spend-down provision applicants. Specific terms, such as income, assets, residency, and share of cost, which affect eligibility are discussed in greater detail in Chapter 5. To fully understand the application and eligibility process, both this chapter and Chapter 5 must be read.

4-1 Application Screening Requirements: The application process first begins at the hospital. The patient receives emergency outpatient or inpatient services from a hospital outside his/her county of residence or at a participating in-county designated hospital. While in the hospital, the hospital finds that the patient may be indigent and begins the screening process to determine if the patient is potentially eligible for HCRA.

A. The hospital must determine if the patient is a resident of the county in which the hospital is located or a resident of another Florida county. For in-depth residency information see Chapter 5, Sections 5-8 and 5- 9, and the County of Residence definition provided in rule and in Appendix A.

   1. If the patient is a resident of the county in which the hospital is located the patient may be eligible for HCRA if the county uses HCRA designated funds for in-county indigent care. A county may not use more than one-half of the total HCRA Funds for in county indigent care. Contact the county for additional information.

   2. If the patient is NOT a resident of a Florida county, then stop the screening process; the patient is not eligible for HCRA.

   3. If the patient is a resident of another Florida county, then continue with the screening.

B. The hospital must check, whenever possible, the Medicaid recipient file to determine if the patient is eligible for Medicaid.

   1. If the patient currently receives Medicaid, then stop the screening process; the patient is not eligible for HCRA.

   2. If the patient is not receiving Medicaid, then continue screening.

C. The hospital must determine if the patient has Medicare.

1. If yes, stop the screening; the patient is not eligible for HCRA.

2. If the patient does not have Medicare, then continue screening.

D. The hospital must determine, to the extent possible, if the patient is potentially eligible for other state or federal programs providing hospital care (such as the Witness Protection Program, Worker's Compensation, etc.).

1. If the patient is eligible for other programs, then he/she is not eligible for HCRA reimbursement. Therefore, the hospital should refer the patient to the program(s) for which the patient is eligible.

2. If the patient is not eligible for other programs or if eligibility for those programs is unclear, then continue screening. Note: If the hospital refers the patient to another program, including Medicare and Medicaid, and also continues with this application, then the hospital should indicate on the application to the county that a referral has been made.

E. The hospital must review any health insurance that the patient may have.

1. If the insurance would pay at least 80 percent of the Medicaid per diem rate or the reimbursement rate negotiated with the county under this program, then the patient is not eligible for HCRA.

2. If no, then continue screening.

F. The hospital must determine if the patient can pay for the services rendered.

1. If yes, the patient is not eligible for this program.

2. If no, have the patient complete the Health Care Assistance Application.

4-2 The Application: Hospitals may get copies of the application from the Agency's HCRA website at http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index.shtml. Refer to Appendix I for a copy of the application.

4-3 Application Deadlines: The hospital must submit the application and photocopies of all supporting documentation, by certified mail, to the certifying agency of the county known or believed to be the patient's county of residence within 30 calendar days of admission or receipt of emergency services. Failure to meet the 30 day requirement could cause the application to be denied.

4-4 Completing Part 1 of the Application, Household Information: Whenever possible, the patient completes Part 1 of the application. However, the hospital must assist the patient if the patient is not able to complete it. From now on, the patient will be referred to as the applicant. The applicant and/or the hospital completes the items in Part 1 as follows.

A. HCRA Box: Check the appropriate box to indicate this is an application for HCRA.

B. County: Enter the county in which the applicant resides. For information about how to determine residency, see Chapter 5, Sections 5-8 and 5-9.

C. Name: Enter the applicant's name on the first line.

D. Social Security Number: Enter the applicant's Social Security number, if available.

E. Date of birth: Enter the applicant's date of birth.

   1. Medicaid covers persons 65 or older, and children under 21 at varying poverty levels (depending on age). If the applicant is under 21 or over 65, the patient most likely is Medicaid eligible. The hospital should check the Medicaid recipient file to determine if the applicant is a Medicaid recipient. If the applicant is a Medicaid recipient, the hospital should seek Medicaid reimbursement through the procedures outlined in the Medicaid Hospital Provider Handbook.

   2. If the applicant is over 65 and has not yet applied for Medicaid, the hospital should refer the patient to the local Department of Children and Family Services (DCF) office. A HCRA application should not be completed for such patients.

   3. If the applicant is under 21 and has not yet applied for Medicaid, the hospital should refer the patient to the local DCF office. However, if the hospital feels there are circumstances that will cause the patient to be determined Medicaid ineligible, the HCRA application should be completed and a note should be attached to the application indicating to the county that a referral has been made.

F. Relationship to applicant: The first line is reserved for the applicant (patient) information.

G. Health insurance: Check whether the applicant has adequate third-party insurance. Adequate third-party insurance is defined in rule.

   1. If the applicant has adequate third-party insurance, check yes and stop the application process; the applicant is not eligible for HCRA.

   2. If the applicant does not have adequate health insurance, check no then continue.

H. Blind: Check whether the applicant is blind.

I. Disabled: Check whether the applicant has a medical condition that:

   1. Has lasted for at least 12 months, is expected to last for at least 12 months, or is expected to result in death; and

   2. Prevents gainful employment.

J. Pregnant: Indicate whether the applicant is pregnant.

K. If the applicant is blind, disabled or pregnant, the hospital should check the Medicaid recipient file to determine if the applicant is Medicaid eligible.

   1. If the applicant is Medicaid eligible, the hospital should seek Medicaid reimbursement through the procedures outlined in the Medicaid Hospital Provider Handbook. A HCRA application should not be completed for Medicaid eligible patients.

   2. Applicants who are pregnant and have not applied for Medicaid should be referred to DCF. A HCRA application should not be completed for such patients.

   3. If a blind or disabled applicant has not yet applied for Medicaid, the hospital should refer them to the Social Security Administration. If the hospital feels there are circumstances that will cause the patient to be determined Medicaid ineligible, the HCRA application should be completed and a note should be attached to the application indicating to the county that a referral has been made.

L. On succeeding lines, the applicant (or hospital, if appropriate) should complete c through k listed above for all persons who are considered as part of the applicant's family unit. If additional lines are needed, provide the additional information on a separate sheet of paper and attach to the application. For a definition of family unit, see Definitions, Appendix A. For further information, see Chapter 5, Section 5-10.

M. Living address: Enter the physical address of the applicant. If the applicant resides in a public institution, he is ineligible for HCRA.

N. Mailing address: Enter the applicant's mailing address if different from the living address.

O. Has the applicant been hospitalized in Florida within the past 12 months: answer yes or no, if yes, provide the name of the hospital and the city where the hospital is located.

P. Phone number: Enter the applicant's home phone number or message number.

Q. Shelter situation: Check the block that best describes the applicant's shelter situation. If "other" is checked, explain the situation. If applicant resides in a public institution, he is ineligible.

R. U.S. citizen: Check the appropriate block. If "no" is checked, enter the applicant's alien registration number. If the applicant is not a U.S. citizen or legally admitted alien, he is not eligible for HCRA.

S. The hospital should review the information that the applicant provided as indicated in the screening procedures discussed in section 4-1.

4-5 Completing Part 2 of the Application – Financial Information: The applicant completes Part 2 of the application, with assistance from the hospital, if needed. The applicant must provide financial information for Part 2 as follows:

A. Income: Enter each type of income received by the family unit, who has it or who receives it, the gross amount of the income, and how often this income is received (weekly, biweekly, monthly, etc.). If space is needed to list additional income sources, provide that information on a separate sheet of paper. For further information regarding income see Chapter 5, Sections 5-11 through 5-14. Note the examples listed of what sources are considered as income.

B. Assets: Enter each type of asset (excluding personal items and home furnishings) owned by the family unit, who has or who owns it, and its value. If space is needed to list additional assets, please provide such on a separate sheet of paper. Further information about assets and how to determine their value may also be found in Chapter 5, Sections 5-20 through 5-24.

4-6 Completing Part 3 of the Application – Declaration: The applicant must sign and date the application, declaring his/her understanding of the requirements and attesting to the accuracy of the information provided. Note that this declaration also provides the applicant's consent for the Agency and the county to contact present or past employers or other individuals who could provide information regarding eligibility.

A. If the applicant is comatose or physically unable to complete or sign the application, then a designated representative (spouse or other responsible relative) may sign and date the application for the applicant in the space provided. When this occurs, the hospital should provide the designated representative's name in print (or type), his/her relationship to the applicant, and his/her address and telephone number, if different from the applicant's.

B. If the applicant is comatose or physically unable to complete or sign the application and there is no designated representative, then the hospital staff may act as the designated representative and sign the application. In these circumstances, the hospital must indicate

in the applicant's signature area that the applicant is incapacitated and that no other designated representative is available.

4-7 Completing Part 4 of the Application – Patient Information: The hospital must complete Part 4 of the application. Part 4 contains information regarding the applicant's stay at the hospital as well as the applicant's previous medical history. The hospital staff must complete Part 4 items as follows:

A. Date admitted or services provided: Enter the date the applicant was admitted to the hospital or received emergency services. If the services provided were not emergency services, then the only way the applicant could be HCRA eligible would be under the following circumstances:

    1. The services were not available, through county funding, in the applicant's county of residence; and

    2. There was prior written approval from the county to cover such services; and

    3. The county and hospital agreed-upon procedures for written authorization and approval of such services were followed.

B. Date of Discharge: Enter the date the applicant was released/discharged from the hospital.

C. Patient Account Number: Enter the applicant's patient account number assigned by the hospital.

D. Deceased: Check whether the applicant is deceased. If yes, provide date and file with Medicaid.

E. Case Management Agency: Not required for HCRA applications.

F. Enrolled/Referred: Not required for HCRA applications; refers to case management agency.

G. Date: Not required for HCRA applications; refers to case management.

H. Previously hospitalized in this hospital in the last year? Check whether the applicant was previously hospitalized or received emergency medical services in your hospital within the last 12 months. If the answer is yes, enter the date such services were provided and either the number of days for inpatient services or the amount charged for outpatient services.

4-8 Completing Part 5 of the Application – Referral Hospital: The hospital must complete this section. Enter the name and address of the hospital that is providing or has provided service. Enter the date the application is sent to the certifying agency. The representative must also sign and print (or type) his/her name on the application, provide his/her telephone number, and check whether the hospital has met its charity care obligation.

4-9 Providing Share of Cost Information to the Counties for Spend-Down Provision Applicants: To be eligible, income-wise, an applicant's monthly income must be at or below 100 percent of the poverty guidelines. Applicants of counties not at their 10 mill cap on ad valorem taxes as of October 1, 1991, whose incomes are between 100 percent and 150 percent of the FPL have another way in which they may become income-eligible: through the spend-down provision.

A. Through the spend-down provision, an applicant may be determined income-eligible if the following requirements are met:

   1. The applicant's monthly gross income four weeks prior to the provision of hospital services was between 100 and 150 percent of the FPL; and

   2. The applicant incurred eligible hospital expenses greater than the difference between his income and 100 percent of the FPL. (This difference is called the applicant's share of cost.)

B. For the county to be able to determine if an applicant is potentially eligible for the spend-down provision, the hospital will need to provide the county with an estimated hospital bill or statement.

C. Further information regarding the spend-down provision and the applicant's share of cost is provided in Chapter 5, Sections 5-15 through 5-19. A list of counties that were not at their 10 mill cap is listed in Section 2-4.

4-10 Reviewing the Completed Application: Once the application has been completed and the hospital staff has gone over the applicant's rights and responsibilities (as indicated below), the hospital staff must then review the application for completeness. The hospital staff must also make sure that all available documentation regarding residency, income, assets, and, if applicable, hospital expenses are obtained and attached to the application.

Income and assets should be reviewed to determine if the applicant is potentially eligible for HCRA. If income or assets exceed the respective limits (see Appendixes S, T and U) the applicant is not eligible for the HCRA.

A. The hospital is strongly encouraged to assist the patient in obtaining verification of income, assets and residency. Lack of verification will not preclude submission of the

application nor constitute a reason to delay the submission of the application beyond the 30 day requirement. However, lack of verification may cause delays in the determination of eligibility or cause a denial of eligibility if the certifying agency is unable to locate the patient after discharge to obtain such verification.

B. Verification of income, assets and residency is required to be attached to the application when filing with a county whose population is 100,000 or less. If the county has chosen to reduce its HCRA obligation, the documentation cannot be re-verified by the county, as long as the documentation complies with section 154.3105, Florida Statutes, and Chapter 5 of this handbook.

C. If the applicant is a potential spend-down provision applicant, the hospital staff must also attach to the application a copy of the applicant's hospital bill or an estimated statement of hospital charges.

D. After the application review has been completed, the hospital staff must submit the application, by certified mail and within the required time frame, to the certifying agency responsible for application processing in the applicant's county of residence. See Section 4-3 for more information.

E. The hospital submits the original application to the county certifying agency, gives one copy to the applicant, and keeps one copy for the hospital's file.

4-11 Applicant's Rights and Responsibilities: HCRA applicants have certain rights and responsibilities of which they should be made aware. Hospital staff and county staff alike must inform applicants of the rights and responsibilities indicated here.

A. An applicant, his/her designated representative, or the hospital has the right to appeal any decision made by the certifying agency concerning the applicant's eligibility under this program. The appeal process is explained in Chapter 7.

B. Applicants, recipients, and designated representatives are responsible for the following:

1. Keeping appointments as required by the certifying agency. Failure to keep an appointment without good cause may result in rejection of the application.

2. Assuming the responsibility to assist in the determination of eligibility.

3. Providing the certifying agency with sources of information and verification concerning the applicant's residency, income, assets, and other eligibility requirements.

4. Providing accurate information with which the county may determine eligibility.

5. Repaying any amount paid on the applicant's behalf if it is later determined that fraud was committed or intentionally incorrect information was provided by the applicant or designated representative that resulted in an inappropriate eligibility determination.

C. In addition, the spend-down provision applicant is responsible for paying the amount of his/her share of cost, as determined by the county of residence, to the hospital. However, an applicant cannot be denied reimbursement through HCRA because he/she has not yet paid his/her incurred share of cost.

Chapter 5

Eligibility Determination Process

This chapter covers the eligibility process pertaining to HCRA. It covers the following in detail:

A. The documents that are to be provided and used to verify residency, income, assets, and eligibility for the spend- down provision;

B. The income and asset levels which the applicant must not exceed to remain eligible for this program; and

C. Which counties are spend-down provision eligible counties.

The Act gave each county the option of determining eligibility under this program or having the state perform this function. If the county chooses to have the state make these determinations, the process is performed by the Agency for Health Care Administration (AHCA).

5-1 Eligibility Determination Deadlines: The county certifying agency has 60 calendar days following receipt of the application in which to determine eligibility and provide the Notification of Eligibility to the applicant and the hospital. The Notification of Eligibility (NOE) is used by counties to notify hospitals and applicants of the applicant's eligibility status. A copy of the NOE is located in Appendix F.

A. If for any reason the county certifying agency cannot determine eligibility within the 60-day limit, then it must notify the hospital, in writing, of the reason for the delay.

B. Counties must also verify assets within the first thirty days of the 60 day eligibility determination limit. This deadline is discussed further in Section 5-22.

5-2 Certifying Agency's Receipt of Applications: Upon receipt of the application, the certifying agency should proceed with the application as follows:

A. The certifying agency completes Part 6 of the application. This section must be completed by either the county or the Agency.

B. The application must be date stamped as to when the application was received and a note should be made indicating the postmark date of the application. These dates are very important. They are used to ensure the timeliness of the submission of the application and the timeliness of the county's determination of the applicant's eligibility.

C. The county certifying agency must enter the worker's name, telephone number, and, once eligibility has been determined, whether the application has been approved or denied.

5-3 County's Screening of the Application: The county's certifying agency screens the application as follows.

A. The certifying agency reviews its caseload files to determine if it has previously determined eligibility for the applicant (or the applicant's family unit) for this or any other program.

1. If a previous case is found, assign a case number to the application and compare the information on the application to the information previously provided to determine:

a. If there is adequate documentation on file to determine residency, income, and assets.

b. If there is previous hospital cost data.

c. If there are any discrepancies between the previous case record and the current application in regard to residency, income, or assets.

2. If no previous case is found, assign a case number to the application. This case number may be the applicant's Social Security Number.

B. Check to see if the patient is eligible for Medicaid, Medicare, or another governmental hospital care reimbursement program. If so, then the applicant is not eligible for HCRA, deny the application.

1. If an applicant is Medicaid eligible and Medicaid has already provided hospital reimbursement for the maximum number of days that Medicaid covers in a state fiscal year, the applicant is still not eligible for HCRA.

2. If an applicant is eligible for Medicaid through the Medically Needy Program, HCRA cannot be used to cover the applicant's share of cost. The applicant is still not eligible for HCRA.

C. Compare the "Date of Admission or Services Provided," or the "Date of Discharge" as appropriate, to the postmark date of the application. If the application was submitted within the appropriate time limit in accordance with Section 4-3, continue with the review. If not, deny the application.

D. Did the patient previously receive emergency services in Florida within the past 12 months? If yes and the application is approved, the certifying agency should notify the county agency responsible for reimbursing the hospital of the dates and hospitals where the applicant previously received services. This is needed to ensure that the applicant's

reimbursement does not exceed HCRA's 45-day cap. For additional information, see Section 3- 16.

5-4 Required Interviews by the Certifying Agency: The certifying agency may require an interview with the applicant if the hospital submits insufficient or conflicting verification to determine eligibility.

A. A certifying agency may schedule an interview for any reason. However, the certifying agency may not deny eligibility if the applicant or designated representative fails to keep such appointment as long as the hospital has submitted sufficient verification to determine eligibility.

B. If insufficient or conflicting documentation has been provided, the county may require an interview. If the applicant fails to keep such an interview, without good cause, the county may consider the applicant is not cooperating and deny the application.

5-5 Determining if Applicant Resides in a Public Institution: If applicant is incarcerated, in a correctional institution, a holding facility for prisoners, arrested or detained awaiting disposition of charges, held under court order as a material witness or juvenile, or a patient in a state mental hospital, then he/she is residing in a public institution. Therefore, the applicant is ineligible for funds through this program.

5-6 Verification of Citizenship: To be eligible, the applicant must be a United States citizen or lawfully admitted alien. If the applicant is not a U.S. citizen, the applicant must indicate his alien registration number on the application. If it is not listed, then the county must request a copy of the applicant's I-94 or I-95 card or other comparable documentation from the Department of Immigration and Naturalization. If adequate documentation is not provided, the county must deny the application.

5-7 Persons Categorically Eligible for a Government Program: Section 154.306, Florida Statutes, defines a HCRA eligible applicant as one who is both a qualified indigent patient and a certified resident of a Florida county. Section 154.304 (9), Florida Statutes, defines a qualified indigent patient as one who meets certain income requirements, who has no or inadequate private insurance, who does not reside in a public institution, and who is not eligible to participate in any other government program which provides hospital care.

If a person appears to be categorically eligible for a government program (such as Medicaid) which provides for hospital care, and this person refuses to apply for the government program, then he or she is not eligible for HCRA. Examples of persons categorically eligible for Medicaid include persons who are blind or disabled or aged, children under the age of 21, and single women who are pregnant.

A. If a person meets one or more of those qualifications, then he or she must apply for Medicaid in order for his or her eligibility for HCRA to be determined. Failure or refusal to apply for Medicaid in such instances indicates the applicant's refusal of his or her responsibility to assist in the determination of eligibility, which is one of the reasons a county may reject an application (Rule 59H-1.015, Florida Administrative Code).

B. If a county has an applicant who appears to be Medicaid eligible and who refuses to apply for Medicaid, the county should have the applicant sign a statement attesting that he or she refuses to apply for Medicaid and acknowledging that failure to do so will result in denial of his or her application for HCRA. If the applicant refuses to sign such a statement and continues to refuse to apply for Medicaid, the county should document the applicant's refusals and complete the Notification of Eligibility, denying the application based on the applicant's refusal to provide information regarding his/her eligibility.

C. The county cannot, however, require all HCRA applicants to apply for Medicaid; rather, it can only require those applicants who appear to be categorically eligible for Medicaid to apply.

D. The county also cannot deny a HCRA applicant who has applied for Medicaid and whose Medicaid application is still pending. The county cannot deny the HCRA application unless such an applicant is determined Medicaid eligible.

Residency Determinations

5-8 Determining County of Residence: The county of residence is a specific county within Florida where an individual establishes or maintains a living arrangement, outside of a medical facility, and which he, or someone responsible for him, considers to be his home with the intent to remain a resident of that county. When the certifying agency is reviewing residency documentation, it should be aware of the following:

A. A visit to another county for any purpose does not make a person a resident of that county, nor does a temporary living arrangement prior to admission in a medical facility.

B. The length of time a person physically resides in a county is not a factor in determining residency.

C. If the applicant or a member of the family unit maintains a primary residence in another county with the intent to return to that other county, then the county of residence is the county in which the primary residence is located.

D. A student attending school away from home is considered a resident of the county in which his parents reside if he is claimed as a dependent for federal income tax purposes.

E. In those situations where one parent resides in-state and one parent resides out-of-state, the county in which the in-state parent resides is considered the county of residence, even if the in-state parent is not claiming the student as a dependent for tax purposes.

5-9 Acceptable Residency Documentation: To be eligible, the applicant must provide or make available corroborating evidence of current residency. If the documentation that the applicant provides indicates the applicant is a resident of another Florida county, the county must return the application to the hospital with a completed Notification of Eligibility. The county should indicate on the Notification that the application is denied and further indicate the county which it believes to be the county of residence. The following documents are considered corroborating evidence:

A. Driver's License.

B. Mortgage, lease, rental receipt or letter from the landlord.

C. Proof of home ownership.

D. Water, electric or other public utility bill in the name of the applicant or spouse for service to a residential address within the county.

E. A state, county or federal document mailed to the applicant to an address within the county.

F. Vehicle registration in the name of the applicant or spouse to the residential address within the county.

G. Voter registration.

H. Proof of children enrolled in public schools.

I. Recent historical record of residence documented through a county department's case record.

J. Other documents of equal weight as those above that verify an applicant's residency.

K. In the absence of any of the above documentation, a declaration of domicile must be accepted.

Determining Household Size

5-10 Determining the Number of Persons in the Applicant's Family Unit: To determine if the family unit's gross income is within the HCRA income standards, the certifying agency must first determine who is in the applicant's family unit. A family unit is defined as one or more

persons residing together in the same household whose needs, income and assets are included in the household budget, excluding roomers and boarders. Members may include the applicant, legal spouse, partner, dependent children, stepchildren, adopted children, partner's children and blood relatives under 21 years of age, unrelated minor children for whom the individual has legal guardianship or custody, legal guardian or natural parents of minor children, minor siblings.

A **boarder** is a person for whom payment is made for room and meals and who is not the spouse or partner of the landlord.

A **roomer** is a person for whom a payment is made for a room and who is not the spouse or partner of the landlord.

A. An applicant who is a roomer or boarder must verify that his/her status as a roomer or boarder by providing a written statement from the landlord stating that the applicant is a roomer or boarder, the amount of the cash payment, that the cash payment is for a room or for room and meals, and that the applicant is not the spouse or partner of the landlord.

B. An applicant who wishes to exclude a person from his/her family unit based on fact that the person is a roomer or boarder must verify that person's status as a roomer or boarder by providing a written statement from the person stating that he/she is a roomer or boarder, the amount of the cash payment, that the cash payment is for a room or for room and meals, and that the person not the spouse or partner of the landlord.

C. A pregnant woman and her unborn child or children are considered to be two or more family members of the same family unit.

Determining Income Eligibility

<u>5-11 Verification of the Family Unit's Income:</u> To determine if the applicant meets the income criteria, the certifying agency must review the applicant's income for the four weeks prior to the time of determination. Therefore, if the hospital has not provided income documentation for the four week period prior to the date of admission or treatment, the certifying agency must request it. The certifying agency must require additional income verification for the 12 month period prior to the time of determination if the income received for the four weeks prior to admission (or treatment) is not representative of the family's current income situation and if it is in the applicant's best interest to do so.

<u>5-12 Income to Be Considered:</u> The certifying agency must consider as gross income the sum of income the applicant's family unit receives or is entitled to receive at the time of determination. Income to be included and verification required are:

A. Gross wages and salary. Certifying agency verifies by pay stubs or a statement from the employer. If the employer refuses or fails to verify the amount of gross wages, the

certifying agency must accept the applicant's statement, unless the certifying agency has verification to the contrary.

B. Child support. Certifying agency verifies by a copy of the check received, a statement from the payor or a copy of the court order.

C. Alimony. Certifying agency verifies by a copy of the check received, a statement from the payor or a copy of the court order.

D. Unemployment compensation. Certifying agency verifies by a copy of the award letter or statement from the state.

E. Worker's Compensation. Certifying agency verifies by a copy of the check or statement from the payor. This could indicate that the applicant has health insurance.

F. Veterans' pension. Certifying agency verifies by a copy of the award letter or a copy of the bank statement if the payment is "direct deposit."

G. Social Security. Certifying agency verifies by a copy of the award letter, a statement from the Social Security Administration or a copy of the bank statement if the payment is "direct deposit." Be sure to determine why the person is receiving the Social Security payment. This could indicate eligibility for Medicaid or Medicare.

H. Pensions or annuities. Certifying agency verifies by a copy of the check, a statement from the payor or a copy of the bank statement if the payment is "direct deposit."

I. Dividends. Certifying agency verifies by a copy of the check or a statement from the payor.

J. Interest on savings or bonds. Certifying agency verifies by a copy of the bank statement or a statement from the payor.

K. Incomefrom estates or trusts. Certifying agency verifies by a copy of the check, legal documents governing the estate or trust or statement from the payor.

L. Net rental income or royalties including rent received from any roomers or boarders. Certifying agency verifies by viewing the most recent income tax returns.

M. Net income from self-employment. Certifying agency verifies by viewing business records and/or the most recent income tax returns.

N. Contributions from any source. Certifying agency verifies by a statement from the payor.

5-13 Income Not Included: The following sources are not included as income for purposes of this program:

A. Food stamps;

B. Income tax refunds;

C. A child's earnings, such as from an after school job; and

D. Student financial aid, if it is for tuition, books, supplies, and school fees.

E. The income of any roomers and boarders.

5-14 Determining if Income is within 100 Percent of the Poverty Guidelines: Add all gross income received by the family to determine if the family unit's income is less than or equal to 100 percent of the poverty level. For purposes of this program, the annual income limits used will be the federal family poverty income limits in effect on October 1 of each year.

A. Compare the total gross income to the chart in Appendix L.

B. If the family unit's income is equal to or below the amount shown in the chart for a household of the same size, proceed to the Section 5-20, "Evaluating the Applicant's Assets."

C. If the family unit's income exceeds the amount shown in the chart for a household of the same size, then stop.

   1. Was your county at its 10 mill cap on ad valorem taxes on October 1, 1991? If it was, then deny the application. Check Section 2-5 for list of counties at their 10 mill cap.

   2. If your county was NOT at its 10 mill cap on October 1, 1991, then your county's residents are eligible for the spend-down provision. Check Section 2-4 for list of counties NOT at their 10 mill cap. If your county was NOT at its 10 mill cap, proceed to Section 5-15 below to determine if the applicant meets the income requirements for the spend-down provision.

Determining Spend-Down Provision Eligibility

5-15 Verification if Income for Spend-Down Provision Applicants: To be considered for the spend-down provision, an applicant must first be a resident of a county that was not at its 10 mill cap on ad valorem taxes as of October 1,1991. Such an applicant's family unit income must be greater than 100 percent of the poverty guidelines and less than or equal to 150 percent of the poverty guidelines.

A. To determine if the applicant meets the spend-down provision income criteria, the certifying agency must review the applicant's income for the one month prior to the time of determination. If the hospital has not provided income documentation for the month prior to the date of admission or treatment, the certifying agency must request it.

B. The certifying agency must require additional income verification for the 12 month period prior to the time of determination if the income received for the month prior to admission or receipt of emergency treatment is not representative of the family's annual gross income.

C. To determine if the applicant is eligible for the spend- down provision, the certifying agency must first add all gross income received by the family unit, determine the monthly gross family unit income, and compare it to the chart provided as Appendix K.

D. If the family unit's income exceeds the amount shown in the chart for a household of the same size, then stop. The applicant is not eligible for the spend-down provision and the application must be denied.

E. If the spend-down provision applicant's family unit income is equal to or below the amount shown in the chart for a household of the same size, then the applicant may be eligible for HCRA reimbursement if he has incurred eligible hospital expenses which exceed his share of cost. The applicant's share of cost is the difference between the applicant's income and 100 percent of the poverty guidelines. See the share of cost formula below.

Share of Cost Formula

Applicant's Income minus 100% of the poverty guidelines (for the Applicant's Family Size) = Share of Cost

5-16 Example of Meeting the Share of Cost: The following is an example of an applicant meeting his share of cost. The applicant has a family size of 1 and his income level is $671. Using the share of cost formula the applicant must have eligible hospital expenses greater than $100 in order to qualify for HCRA through the spend-down provision.

$671 (Applicant's Income)
- 571 (100% of poverty guidelines for Family Size of 1)
= $100 (Applicant's Share of Cost)

5-17 Hospital Expenses Counted toward Meeting the Applicant's Share of Cost: To determine if the applicant may have met his share of cost, the county must first determine if the applicant has eligible hospital expenses that exceed his share of cost. Only the applicant's

hospital expenses that are eligible for HCRA reimbursement may be used toward meeting his share of cost.

A. Allowable hospital bills to be counted toward the applicant meeting the share of cost include the following:
   1. The hospital bill for the date(s) of service indicated on the application, and

   2. All other hospital bills for related services, which would have otherwise qualified for HCRA payment, that were provided during the four weeks prior to the date(s) of service indicated on the application.

B. An applicant does not need to meet an additional share of cost for follow-up care which occurs within four weeks from the date of discharge indicated on the application.

C. The applicant must incur such hospital bills to be eligible for HCRA; however, the county may not delay determining eligibility if the applicant has not yet paid his share of cost.

<u>5-18 Applicant's Medical Expenses Not Counted toward Meeting the Share of Cost:</u> The following expenses may not be used toward the applicant meeting his HCRA share of cost.

A. Bills for physician services or bills from other non- hospital providers.

B. In-county hospital bills when determining share of cost for out-of-county expenses.

C. Out-of-county hospital bills when determining share of cost for in-county expenses.

D. Bills for services provided at participating hospitals which would NOT have qualified for payment through HCRA.

E. Bills for prior hospital services unrelated to the applicant's condition specified on his/her HCRA application.

F. Bills for follow-up care that is provided after the four (4) weeks subsequent to the date of discharge.

<u>5-19 Final Determination of Applicant's Meeting the Share of Cost – UB-04 Claim Form:</u>
The county will not be able to make the final determination of whether the applicant met his share of cost until it receives the UB-04 claim form from the hospital. Final determination is discussed in detail in Chapter 6, Sections 6-16 through 6-19. Therefore, if the applicant has met all other eligibility criteria and appears to meet the share of cost based upon his estimated hospital bills, the county will continue with determining the applicant's overall eligibility by evaluating the applicant's assets.

Determining Asset Eligibility

5-20 Evaluating the Applicant's Assets: The certifying agency must review the applicant's assets to determine if the assets are within the HCRA limits. Some assets are excluded from being considered as "available." For this, HCRA uses the same asset guidelines used for determining eligibility for SSI, unless otherwise indicated in this handbook. However, HCRA uses the same asset limits that are used for the Medicaid Medically Needy program.

5-21 Excluded Assets: The following assets, if owned by a member of the family unit, are NOT considered in evaluating assets:

A. One homestead: A homestead is defined as a house, trailer, boat or motor vehicle in which the family unit resides.

   1. If the family unit leaves the homestead and establishes residence elsewhere, the homestead becomes an asset regardless of how it is considered for tax purposes.

   2. If a member of the family unit continues to reside in the homestead, it will not be considered an asset.

   3. If, in the case of a single person family unit, the individual is absent because of a physical or mental illness, and the individual intends to return, the homestead will not be considered an asset.

B. Household furnishings.

C. One automobile in operating condition, regardless of value.

D. Clothing.

E. Tools used in employment.

F. Cemetery plots, crypts, vaults, mausoleums and urns.

G. Produce and animals raised for the applicant's personal home consumption.

5-22 Verification of Assets That Are Considered: The certifying agency must verify assets if such verification is not provided by the hospital when the application is submitted.

A. Such verification must be completed within 30 days of receipt of the application.

B. If verification is not requested and received within 30 days of receipt of the application, the assets will be accepted as stated in the application unless the certifying agency has conflicting documentation or documents by independent means that the applicant's assets exceed the limits. If the applicant's assets exceed the limits or if the applicant fails to resolve the conflicting data, then the certifying agency must deny the application.

C. Such independent means include having verification of assets in a case record when assistance was previously provided to the applicant or having asset documentation provided by other county or state agencies.

5-23 Assets to Be Considered: In order to be considered, an asset must first be "available" to the applicant or family unit.

A. An asset is available if the applicant or a member of the family unit has the right, authority or power to liquidate the property or his share of the property.

B. The following assets, if "available," must be considered toward the asset limit:

1. Checking and saving accounts.

   a. The value of a checking or saving account excludes amounts deposited in the four weeks prior to admission because such funds are counted as income.

   b. The value of a checking or saving account is verified by photocopies of current bank statement or a statement from the bank.

2. The equity value of real property other than the homestead. The value is verified by the county appraiser of the county in which the property is located. The equity value is determined by subtracting the amount of any encumbrances from the value of the asset.

3. The cash surrender value of life insurance, if the combined face value of all policies owned by the family unit exceeds $1,500. The value is verified by copies of the policies.

4. Additional automobiles or motor vehicles. The value is determined by Blue Book.

5. Recreational vehicles. The value is determined by a statement from a commercial seller of such vehicles and verified by photocopies of registration.

6. Trusts. The value is based on the principle of the trust and verified by a statement from the trustee.

7. Stocks, bonds and other investment assets. The value of such is verified by the value listed in stock value section of the newspaper or statement from a knowledgeable source.

<u>5-24 Determine whether Assets Are within the Limits:</u> Compare the total includable assets to the chart located in Appendix U.

A. If the family unit's assets exceed the assets limit for the same household size shown in the chart, stop. Deny the application.

B. If the family unit's assets equal or are less than the assets limit for the same household size shown in the chart, approve eligibility.

Eligibility Notification

<u>5-25 Completing the Notification of Eligibility:</u> Once eligibility is determined, the certifying agency must complete and provide the NOE to the applicant and the hospital within ten (10) days of the date of the determination and within the time limits indicated at the beginning of this chapter. A copy of the NOE is provided as Appendix F.

The certifying agency completes the form as follows:

A. Enter the name of the county of residence of the applicant;

B. Enter the name and address of the certifying agency making the determination;

C. Check the box before Health Care Responsibility Act;

D. Enter the applicant's name and address;

E. Enter the date the Notification is mailed;

F. Enter the case number assigned to the application by the certifying agency;

G. Enter the name of the hospital that provided the services or treatment;

H. Enter the hospital's patient account number;

I. For eligible non-spend-down provision cases, check the appropriate box. Enter the date emergency services were provided or the date of admission as appropriate;

J. For eligible spend-down provision cases, check the appropriate box. Enter the date emergency services were provided or the date of admission as appropriate. Enter the applicant's share of cost amount. Please note that this paragraph of NOE indicates to the

applicant that final eligibility for the spend-down provision will be based upon the applicant's meeting the share of cost as determined through the county's receipt and review of the UB-92 claim form from the hospital;

K. For ineligible cases, check the appropriate block. Enter the date emergency services were provided or the date of admission as appropriate. Enter the appropriate administrative rule number in the space provided. A list of rule numbers and summaries of these rules are provided on the back of the form. In the "Reason" section, enter an explanation of why the application was denied.

5-26 Examples of Completing the Notification of Eligibility for the Ineligible Applicant: The following are examples of how the certifying agency would complete the NOE for applicants determined ineligible for HCRA:

A. If the hospital submitted the application to the wrong county, the county enters rule number "59H-1.009" and in the "Reason" section states that the applicant is a resident of _____________ county.

B. If the application is denied because the family unit has excess assets, the county enters rule number "59H- 1.0035(6)" and in the "Reason" section states that assets exceed program limits.

C. If the application is denied because the applicant's hospital expenses did not exceed his share of cost, the county enters rule number "59H-1.0035(35)" and in the "Reason" section states that the hospital bill did not exceed the applicant's share of cost.

5-27 Sending the Notification: The certifying agency mails the original Notification to the applicant, a copy to the hospital, and retains a copy in the applicant's case record. The certifying agency may wish to mail the notification form via certified mail to insure receipt by the hospital within the required time frame.

5-28 Monthly Caseload and Appeals Report: The certifying agency is responsible for completing the Monthly Caseload and Appeals Report on a monthly basis as indicated in Chapter 2 of this handbook. When the Agency serves as the certifying agency, the Agency will complete the Monthly Caseload and Appeals Report for that county.

Chapter 6

Claims Processing

This chapter covers the claims processing procedures pertaining to the Health Care Responsibility Act (HCRA). The claims processing and fiscal reporting procedures described in this handbook are the minimum standards that will be applied in each participating county in the state. These procedures and related reports may need to be adapted and modified by certain counties due to differences in claim volume and administrative systems. This chapter is divided into four parts: Time Standards, Hospital Responsibilities in Processing Claims, County Responsibilities in Processing Claims, and State Comptroller Responsibilities.

Time Standards

6-1 Hospital Claims Processing Time Standards: The hospital has six months from the date of the Notification of Eligibility, approving an applicant's eligibility, to submit a completed UB-04 claim for payment to the appropriate county claims processing agent. The county may accept or deny any claim submitted after the six months submission time period.

A. The hospital must submit a copy of the patient's Notification of Eligibility, with the completed UB-04 claim form to the county billing agent. Reimbursement for service provided should be paid at the rate authorized at the time of service. If a hospital has been granted a revised/interim per diem rate by Medicaid, official notification of this change in per diem must be submitted with the claim in order for the county to pay the claim at the new rate.

B. Claims may be submitted individually or in batches, depending on the hospital's claim volume.

C. If an administrative hearing has delayed the submission of a claim, the hospital has 30 days from the date of the final order approving reimbursement to submit such a claim to a county.

6-2 Resubmitting a Denied Claim: The hospital may resubmit a claim denied by a county due to its missing information in the fields on the UB-04 listed as mandatory in Section 6-11. However, the corrected claim must be resubmitted within six months of the date of the Notification of Eligibility.

6-3 County Claims Processing Time Standards: The county has 90 days from the date it receives the claim to complete its adjudication and transmit its reimbursement, if appropriate, to the hospital. This excludes any claim being contested under an administrative hearing. The county should date stamp or otherwise mark "received" on the claim form to verify the receipt date. It is on this date that the 90-day time period for claims processing begins.

6-4 Hospital's Course of Action if Claims Processing Exceeds Time Standards: If the hospital is not notified by the county of the disposition of a claim within the required 90 days, the hospital should contact the county billing agent and request the status of the claim and attempt to resolve any issues delaying its adjudication.

A. If there are no issues and the hospital has not received payment within the 90 day deadline, then the hospital may request that the State Comptroller's office reimburse the hospital directly from any funds owed the county.

B. If the issues cannot be resolved by the county and the hospital, the hospital may request a county level hearing or administrative appeal. The hospital may also contact the Agency for technical assistance at the address or telephone number provided in Chapter 1, Section 1-11.

   1. The appeal process is discussed in Chapter 7.

   2. If the claim is disputed and payment is not received from the county determined to be responsible within 60 days after all legal and administrative remedies have been exhausted, then the hospital may request that the State Comptroller's office reimburse the hospital directly from any funds owed to the county.

Hospital Responsibilities for Claims Submission and Processing

6-5 Basis Rules for Claim Preparation: The hospital is responsible for preparing the UB-04 claim form for each HCRA applicant for which it has received a Notification of Eligibility from the certifying agency indicating the applicant is eligible. Hospitals may not submit claims for payment prior to the receipt of the Notification of Eligibility.

The hospital must complete the claim form in the following manner:

A. Always use the UB-04 claim form.

B. Be sure the information on the UB-04 form is legible.

C. Enter all information with a typewriter or print with a black pen.

D. Determine if there is any third party insurance or other payor coverage that would affect an applicant's eligibility or amount of reimbursement. See Third Party Coverage, Section 6-6, for more information on payment involving third party payors.

E. Prepare, if inpatient services were provided, an inpatient claim.

   1. The hospital must use one claim form for each inpatient stay.

2. The hospital should refer to Appendix H for step-by- step instructions for completing the UB-04 inpatient claim and also for an example of a properly completed inpatient claim.

F. Prepare, if outpatient services only were provided, an outpatient claim.

1. The hospital must use one claim form for each outpatient date-of-service.

2. The hospital should refer to Appendix H for instructions that identify those outpatient fields on the UB-04 that are either not required or are completed differently from an inpatient claim.

G. Complete the UB-04 claim form fully and accurately.

1. If the hospital submits an incomplete or inaccurate claim form, the county may deny the claim.

2. The hospital should review the claim once it has been completed to assure that the mandatory items identified in the Section 6-11, In-Depth Review of UB-04 Claim Form, are completed.

6-6 Third Party Coverage: The hospital must determine the existence of private insurance or other coverage for a patient prior to submission of a claim, because third party coverage may affect an applicant's eligibility.

A. If there is third party coverage, the county will make payment under this program only if the third party coverage is less than 80 percent of the hospital's per diem rate or less than the written reimbursement rate agreed upon by the county and the hospital.

B. There may be joint payment on a claim by both this program and such third party coverage (as indicated in item a. above) provided the combined total payment does not exceed 100 percent of the Medicaid per diem rate. For information on calculating the amount of HCRA reimbursement allowed when combined with third party coverage, see Section 6-20.

C. The hospital must pursue other insurance or other coverage until such payment is received before submitting a claim to the county billing agent for reimbursement.

D. The hospital must identify the actual amount of reimbursement received from the other coverage in claim FIELD 50. The hospital must prepare the UB-04 showing other coverage as indicated in Appendix H.

E. If payment from other insurance or other coverage has been delayed and the hospital is concerned about the six months submission time frame, the hospital should submit a claim to the county billing agent and identify the estimated amount of reimbursement expected from the other insurance or other coverage in claim FIELD 50. The hospital is responsible, however, for notifying the county of any change in the actual amount of third party reimbursement received.

F. If or when the hospital receives reimbursement from a third party or any other source, it is the hospital's responsibility to refund any amount paid by the county as outlined in Section 6-9.

6-7 HCRA Payment as Payment in Full: If an applicant's claim is adjudicated as payable, the payment made to the hospital is considered as payment in full, except for non-covered services and for the spend-down provision applicant's share of cost.

6-8 Collecting the Applicant's Share of Cost: If the applicant is a spend-down provision applicant and the county adjudicates the applicant's claim as payable, then the county will reduce the hospital's reimbursement by the amount of the applicant's share of cost before making payment. The applicant's share of cost will be indicated by the county on the applicant's Notification of Eligibility. The hospital may bill the applicant for the applicant's share of cost and the cost of other non-HCRA-covered services.

6-9 Refunding HCRA Payments to the County: If, after a county has paid a claim, the hospital receives payment from a third party (including Medicaid) for the same hospital services, the hospital must refund the HCRA funds to the county within 30 days of receipt of such payment. The refund is made as follows:

A. If the third party payment received was from a governmental reimbursement program, such as Medicaid, Medicare, or Worker's Compensation, the hospital must refund the entire HCRA payment to the county. This is because the applicant's eligibility for another governmental hospital reimbursement program makes him ineligible for HCRA.

B. If the third party payment was from a non-governmental entity (such as an insurance company or a payment as a result of a law suit), and such payment was not listed on the UB-04, the hospital must compare the third party payment received to 80 percent of the Medicaid per diem rate, or other negotiated rate.

   1. If the third party payment received was equal to or greater than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund the full HCRA payment to the county.

a. For example: The county paid the hospital $500 through HCRA, a third party paid the hospital $400 for the same inpatient day of covered service, and the Medicaid per diem rate was $500 (no other reimbursement rate was negotiated).

   A full refund is required because the $400 paid by the third party is equal to 80 percent of the Medicaid per diem rate. Therefore, the third party payment is considered adequate third party insurance, as defined in rule, and the hospital must refund the full $500 to the county.

2. If the third party payment received was less than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund to the county the difference between the combined reimbursement received (county and third party) and 100 percent of the Medicaid rate.

   a. For example: The county paid the hospital $500 through HCRA, a third party paid the hospital $300 for the same inpatient day of covered service, and the Medicaid per diem rate was $500. The county is only obligated to have paid the hospital $200; therefore, the hospital must repay the county $300 as indicated in the following calculation.

      $800 (Combined HCRA County and Third Party Payor Reimbursement)
      - $500 (100% of Medicaid Per Diem Rate)
      = $300 (Amount Hospital Refunds to the County)

C. If the third party payment was from a non-governmental entity, and was under-estimated on the UB-04, the hospital must determine if the payment received was equal to or more than 80 percent of the Medicaid per diem rate or other negotiated rate, if there was another reimbursement rate negotiated.

1. If the third party payment was equal to or greater than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund the full HCRA payment to the county.

2. If the third party payment received was less than 80 percent of the Medicaid per diem rate, the hospital must repay to the county the difference between the estimated insurance indicated on the UB-04 claim form submitted to the county and the actual payment received.

County Responsibilities for Claims Processing

6-10 County's Review of Claim and Hospital Notification: The county billing agent must review the claim to verify that the appropriate Notification of Eligibility is attached to each claim and that the claim form was submitted within the required time frame.

A. If the Notification is not attached, deny the claim and return it to the hospital with a statement that it was denied because the Notification was not attached.

B. If the Notification is attached, verify that the claim form was submitted (postmark date) within six months of the notification of eligibility. Also compare the claim information with that of the Notification in order to confirm the eligibility status of the patient, the date(s) of hospital service provided, and the name of the hospital providing service.

   1. If the claim was mailed to the county more than six months after the date of the Notification, the county may deny the claim. If the postmark date of the claim is within the six months after the date of the Notification, then proceed with comparing the Notification information to the information provided on the applicant's claim form.

   2. If the information on the Notification conflicts with the claim, deny the claim and return it to the hospital with a statement of why it is denied.

   3. If the information is consistent with the claim, proceed with the review.

   4. If the hospital resubmits a completed claim form and Notification within the six months' time frame, the county must continue with the claims reimbursement process.

6-11 In-Depth Review of UB-04 Claim Form: The county billing agent must review the claim form in accordance with the instructions in this chapter. The county must review the claim form to ensure that the following fields on the UB-04 claim form are complete. The completion of these fields is MANDATORY. The claim example in Appendix H identifies the location of these fields.

Provider Name and Address	Field 01
Financial Classification Code	Field 02
Type of Bill	Field 04
From-Thru Dates	Field 06
Patient Name	Field 12
Patient Birthdate	Field 14
Admission Date (Inpatient Only)	Field 17
Type of Admission (Inpatient Only)	Field 19
Source of Admission	Field 20
Discharge Hour	Field 21
Patient Status (Inpatient Only)	Field 22
Condition Code	Fields 24-30
Occurrence Code and Date	Fields 32-35 A and B
Revenue Code	Field 42

Revenue Description	Field 43
Service Units	Field 46
Total Charges	Field 47
Payer Identification (Inpatient Only)	Field 50
Principal Diagnosis	Field 67
APR-DRG Code (Inpatient Only)	Field 71
Provider Representative Signature	Field 85
Date Bill Submitted	Field 86

A. If one or more of these fields are incomplete or omitted, the claim may be adjudicated as denied. However, the county may obtain the missing information from the hospital by telephone and thereby avoid the possible denial of the claim.

B. If the hospital resubmits a completed claim form and Notification within the six-month time frame, the county must continue with the claims reimbursement process.

C. For Fields 42 and 43, inpatient and outpatient revenue center codes and descriptions are identified in Section 6-13.

D. Field 50 is mandatory only if there is insurance (other payor) coverage.

6-12 Review of Field 19: Inpatient Care/Emergency Care: Inpatient care under this program is primarily provided for the purpose of treatment for emergency conditions. Therefore, the claim must identify the type of admission in FIELD 19.

A. The code '1' in this field indicates that the patient was admitted under an emergency situation.

B. A claim may be denied for a code other than '1' in this field, unless the county and the hospital have an agreement to provide non-emergency treatment under the program. The county billing agent should be notified of such agreements. See Section 3-5 for further information regarding such agreements.

6-13 Adjudication of Claims by the County: Once the claim and Notification have been reviewed, a decision of adjudication can be made as to whether the claim is denied or approved for payment.

A. The county billing agent should review Chapter 3, Covered Services, to become familiar with the days of care covered by HCRA, the hospital services covered by HCRA, and the outpatient reimbursement limits.

Inpatient Revenue Center Codes are covered in Appendix A of the Florida Medicaid Hospital Services Coverage and Limitations Handbook, which is available on the