Medicaid fiscal agent's website at http://mymedicaid-florida.com. Click on Provider Services, Support, Handbooks.

Appendix B of the Florida Medicaid Hospital Services Coverage and Limitations Handbook has the list of revenue center codes exclusively for outpatient hospital billing. For each different outpatient revenue code, HCRA will pay the outpatient rate one time per day regardless of the charges or the number of units billed. Exceptions to the rate payment are outpatient laboratory and pathology revenue center codes. Those require a five-digit HCPCS procedure code in Form Locator 44 on the UB-04 claim form. The outpatient lab codes are on the Florida Medicaid Provider Reimbursement Schedule, which is available on the Medicaid fiscal agent's website at http://mymedicaid-florida.com. Click on Provider Services, Support, Fee Schedules, Independent Laboratory.

B. Reimbursement may not exceed 45 inpatient days of service per county fiscal year through HCRA.

C. The county must review UB-04 FIELDS 24-30 and FIELD 50 to determine if there is insurance (other payor) coverage.

   1. If there is third party coverage, the county may 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 if the agreed upon rate is greater than 80 percent of the Medicaid per diem rate.

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

6-14 Determining the Amount of Reimbursement for Inpatient Claims for Counties at Their 10 Mill Cap on Ad Valorem Taxes: Counties at their 10 mill cap on ad valorem taxes as of October 1, 1991, reimburse hospitals for inpatient care at a rate equal to 80 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed upon. If an inpatient claim is approved for payment, the actual payment is based on the four-digit APR-DRG code.

6-15 Determining the Amount of Reimbursement for Inpatient Claims for Counties Not at Their 10 Mill on Ad Valorem Taxes: Counties NOT at their 10 mill cap on ad valorem taxes as of October 1, 1991, reimburse hospitals for inpatient care at a rate equal to 100 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed

upon. The county billing agent determines the amount of reimbursement for inpatient claims by first determining if the claim is for a spend-down provision applicant.

A. The county billing agent determines if the claim is for a spend-down provision applicant by reviewing the applicant's Notification of Eligibility. The county certifying agency will have indicated on the Notification if the applicant is a spend-down provision applicant.

B. If the Notification indicates that the applicant is NOT a spend-down provision applicant, then the payment is based on the four-digit APR-DRG code.

C. If the Notification indicates that the applicant is a spend-down provision applicant, then the county determines the amount of payment as indicated below.

6-16 Determining the Amount of Reimbursement for Inpatient Claims for Spend-Down Provision Applicants: For the spend-down provision applicant, claims payment for an inpatient claim is handled differently than for any other type of HCRA applicant. To determine the amount of payment for an inpatient claim for such an applicant, the county billing agent uses the following procedures:

A. The county must first determine the amount of reimbursement for which the applicant would have been eligible if he was not a spend-down provision applicant. The county billing agent, therefore, determines reimbursement to the hospitals for inpatient care at a rate equal to 100 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed upon.

B. Deduct from the above figure the applicant's share of cost as indicated on the Notification of Eligibility. The remainder is the amount of payment to be made to the hospital.

1. If the share of cost exceeds the reimbursement amount determined in item a. above, then the applicant is not eligible for HCRA and the claim must be denied.

2. If the applicant has already met his share of cost by being financially responsible for a previous hospital stay which would have been HCRA eligible, then no deduction is made. Such a stay must have occurred within the 4 weeks prior to the date of admission/service indicated on the applicant's Notification of Eligibility.

3. On whichever day the applicant has met his share of cost, he becomes eligible for HCRA reimbursement for the remainder of that day. All remaining days are paid at 100 percent of the Medicaid per diem rate or other negotiated rate.

6-17 Examples of Reimbursements to Hospitals for Spend-Down Provision Applicants: The following are examples of reimbursements to hospitals for spend-down provision eligible applicants:

A. Example 1: Bob's share of cost is $372. He has one covered day of service. The Medicaid reimbursement is calculated at $500. The total HCRA reimbursement to Bob's hospital is $128.

$500 (1 day at the Medicaid per diem rate)
- 372 (share of cost)
$128 (total HCRA reimbursement)

B. Example 2: Sam's share of cost is $572. He has two covered days of service. The Medicaid reimbursement is calculated at $1,000. The total HCRA reimbursement to Sam's hospital is $428:

$1,000 (2 days based on the APR-DRG code)
- 572 (share of cost)
$ 428 (total HCRA reimbursement)

C. Example 3: Joan's share of cost is $594. She has only 1 day of covered service. The Medicaid reimbursement is calculated at $500. Joan is not eligible for HCRA reimbursement because she has not met her share of cost:

$500 (1 day at the Medicaid per diem rate)
-594 (share of cost)
$-94 (unmet share of cost)

D. Example 4: Joan is admitted again to the out-of-county hospital (two weeks after her first admission) for services related to the first episode of care. These services are not of an emergency nature; however, the services are unavailable in Joan's county of residence and her county has "prior approved" her HCRA application provided she meets her share of cost. Joan is hospitalized for three days (two days of covered service). The Medicaid reimbursement is calculated at $1,000.

Because the second admission occurs within 4 weeks of the discharge date of Joan's admission and it is related to the first episode of care, Joan has already met $500 of her share of cost in her first episode of care. Therefore, Joan needs only to meet $94 in her second episode of care in order to have the remainder of her second bill paid through HCRA.

$1,000 (2 days based on APR-DRG code)
- 94 (unmet share of cost)
$ 906 (total HCRA reimbursement)

6-18 Determining the Amount of Reimbursement for Outpatient Claims for Non-Spend-Down Provision Applicants: If an outpatient claim is approved for payment, the actual payment is based on the revenue center codes listed in Field 42 on the claim, the Medicaid rate or agreed upon reimbursement rate, and any lab/pathology procedure code fees (outpatient revenue center codes 300 through 319).

A. The actual payment must take into consideration the $1,500 cap limitation described in Covered Services, Chapter 3, Sections 3-16 and 3-17.

B. Each unique outpatient revenue center the claim, excluding codes 300 code identified on through 319, is reimbursable at 100 percent of the Medicaid outpatient line item rate or other negotiated rate. A listing of reimbursable outpatient revenue center codes is provided in Section 6-13.

C. For each outpatient revenue center code 300 through 319 (laboratory/pathology codes) listed in FIELD 42, there must be a corresponding description in FIELD 43 and a corresponding five digit procedure code in FIELD 44. Each of these procedure codes has its own maximum reimbursement amount (as indicated in Section 2-11 and Section 6-13).

D. Reimbursement is limited to each unique revenue center code. However, for revenue center codes 300-319 (laboratory and pathology codes), payment is made for each unique laboratory/pathology procedure code identified on the claim. No payment may be made for duplicate listings of the same codes.

E. The total payment to the hospital is the sum of the payments for each unique revenue center code and each unique laboratory/pathology procedure code.

F. For example, an outpatient claim indicates the following in FIELDS 42, 43, and 44.

42 Revenue Code	43 Description	44 HCPCS/Rates
250	Pharmacy	
300	Laboratory	87118
300	Laboratory	87068
450	Emergency Room	

The hospital's outpatient line item reimbursement rate is $50.00. All revenue codes are reimbursable (see Section 6-13). Codes 250 and 450 are unique; therefore, payment for these two codes is $100.00 ($50 X 2). Code 300 indicates laboratory codes. Therefore, to determine payment for this code, FIELD 44 must be reviewed. Each code 300 has a unique procedure code (87118 and 87086) and each is reimbursable. These code numbers must be reviewed against the most recent Laboratory and Pathology fee listing (see Section 6-13). The maximum fee listed payable by Medicaid for Code 87118 is $8.50.

The maximum fee for Code 87086 is $6.00. Unless the county has a written agreement to pay an amount other than the maximum allowed by Medicaid, the amount the county must pay for these codes is $14.50 ($8.50 and $6.00). Therefore, the total payment made by the county to the hospital is $114.50.

6-19 Determining the Amount of Reimbursement for Outpatient Claims for Spend-Down Provision Applicants: Like inpatient claims payment, outpatient claims payment for the spend-down provision applicant is handled differently than for any other type of HCRA applicant. To determine the amount of payment for the spend-down provision applicant's outpatient claim, the county billing agent uses the following procedures:

A. The county must first determine the amount of reimbursement for which the applicant would have been eligible if he was not a spend-down provision applicant by using the procedures indicated in Section 6-18. This would be the sum of the payments for each unique revenue center code and each unique laboratory/pathology procedure code.

B. Deduct from the above figure the applicant's share of cost as indicated on the Notification of Eligibility. The remainder is the amount of payment to be made to the hospital.

    1. If the share of cost exceeds the amount determined in item a. above, then the applicant is not eligible for HCRA and the claim should be denied.

    2. If the applicant has already met his share of cost by a previous hospital stay which would have been HCRA eligible, then no deduction is made. Such a stay must have occurred within 4 weeks of the date of admission/service indicated on the applicant's Notification of Eligibility.

6-20 Calculating Reimbursement with Third Party Insurance: If a claim has been adjudicated as payable, and also identifies an amount paid by other insurance, the reimbursement amount is calculated as follows:

A. Use the hospital's full (100%) Medicaid per diem rate (even if the county is using a per diem rate that is less than the Medicaid rate). The use of the full Medicaid per diem is intended to be an incentive for the hospital to pursue all possible insurance coverage.

B. Multiply this per diem by the number of approved days.

    1. If this amount is less than or equal to the insurance amount identified on the claim, no payment under this program is allowed.

    2. If this amount is greater than the insurance amount identified on the claim, the difference between the two amounts is the total reimbursement allowed under this program. If the applicant is a spend-down provision applicant, the total

reimbursement allowed is the difference between the amount in item b. and the sum of the insurance amount and the applicant's share of cost.

6-21 No Retroactive Per Diem Rate Adjustments: Reimbursement for service provided should be paid at the rate authorized at the time of service. Therefore, if a hospital has been granted a revised/interim per diem rate by Medicaid, the hospital must notify the county of this change in per diem, in order for the county to reimburse the hospital at the new rate.

A. Medicaid per diem rates are updated and distributed by the Agency to each county billing agent in July of each year.

B. If a Medicaid rate is not available for a hospital, the county billing agent should contact the Agency's Bureau of Central Services.

C. The per diem rate utilized at the time of claim adjudication is considered the final rate for that claim. No retroactive per diem rate adjustment is allowed.

6-22 Transmitting Reimbursement to the Hospital: Once the total amount of payment has been identified for a claim or a group of claims, this information is submitted to the appropriate county financial office to prepare and transmit a reimbursement check to the hospital.

A. The county billing agent must attach to each reimbursement check a report listing specific information on the adjudicated claims covered in the reimbursement check.

B. The county billing agent must report the following information to the hospital on each paid claim:

1. Patient's name;

2. Patient's Social Security number, if known;

3. Date of admission;

4. Actual paid days (days paid by the program); and

5. Amount paid.

C. The suggested form to be used for this supporting information is found in Appendix I.

6-23 Denied Claims: The county must notify the hospital on those occasions when a claim is denied. A report on denied claims must be provided to the hospital indicating the reason for denial. The county billing agent must report the following information:

A. Patient's name;

B. Patient's Social Security number, if known;

C. Date of admission;

D. Indication that the amount paid is zero; and

E. A brief reason as to why the claim was denied.

The county must also include on the report a statement informing the hospital of its right to request an administrative hearing on any of the claims denied.

6-24 Failure to Provide Payment: If the responsible county does not pay the hospital for an eligible applicant within 90 days of receipt of a claim, or if the claim is disputed and payment is not received from the county within 60 days after all legal and administrative remedies have been exhausted, the hospital may seek payment from state funds due the county through the State Comptroller's office as indicated below.

State Comptroller Responsibilities

6-25 Hospital's Certification for Payment to the State Comptroller's Office: If the county fails to provide payment within the time frames indicated above, the hospital may request payment from the State Comptroller's office by submitting the following information to the Comptroller:

A. A certification of the name of the patient, the patient's identification number, the documented date that the claim was received by the county, and the amount of the claim;

B. A copy of the claim that was submitted to the county;

C. A copy of the Notification of Eligibility;

D. A copy of the final order (for disputed claims);

E. Documentation, if applicable, that the county of residence was at its 10 mill cap on ad valorem taxes as of October 1, 1991;

F. Any other documentation the Comptroller might require that would support payment of the claim.

The hospital must submit this information to:

Department of Financial Services
Accounting and Auditing
200 East Gaines Street
Tallahassee, Florida 32399-0318

If, after the State Comptroller has paid a claim, the hospital receives payment from a third party (including Medicaid) for the same hospital services, the hospital **must refund the payment to the State Comptroller within 30 calendar days of receipt of such payment from the third party**.

6-26 State Comptroller Responsibilities: The State Comptroller pays such claims to the hospital, provided the hospital has submitted all of the documentation listed in 6-25 above.

A. The Comptroller reimburses hospitals for eligible indigent patients from any funds due to the county under any revenue-sharing fund established by the state, except as otherwise provided by the state constitution.

B. The Comptroller will forward the amount delinquent to the hospital within 45 days of the date of receiving the hospital's certified notice.

1. The Comptroller will reimburse hospitals at a rate not less than 100 percent of the hospital's Medicaid per diem rate.

2. If the hospital or county provides the Comptroller with documentation that the county was at its 10 mill cap on ad valorem taxes as of October 1, 1991, then the Comptroller will reimburse the hospital at a rate not less than 80 percent of the hospital's Medicaid per diem rate.

3. If the hospital or county provides the Comptroller evidence of a different negotiated rate or if the order of a hearing officer indicates a different rate of reimbursement, then the Comptroller will reimburse the hospital at the negotiated or court ordered rate.

Chapter 7

Appeal Process

This chapter covers the appeal process and the responsibilities of the patient, the hospital, the county, the Agency, and any other organizations or offices involved in the administration of the Health Care Responsibility Act (HCRA). An appeal may be requested when there is a denial of a claim or an application. It is suggested that before an appeal is made, every effort be made by the parties involved to resolve the issue. The Agency will provide technical assistance as needed.

7-1 Appeals: The following persons/entities may request an appeal:

A. The hospital, if eligibility or county of residence is denied;

B. The hospital, if reimbursement is not received from the county of residence;

C. The county, if it believes the services provided by the hospital were not medically necessary or appropriate.

D. The county, if the hospital delays in refunding any amounts received by the county and a third party payer.

7-2 Time Standards: All appeals must be requested within 90 days from the date of the Notification which denies eligibility or reimbursement.

A. The Notification of Eligibility instructs the hospital to contact the certifying agency to appeal a decision. It is, therefore, the responsibility of the certifying agency to forward such requests to the appropriate source within five calendar days of the receipt of the request.

B. Informal county hearings must be held within 30 days of the date of request, unless both parties agree to a later date.

C. Written decisions on all appeals must be provided by the hearing officer to both parties within 45 days of the hearing date.

7-3 Ways That Appeals May Be Conducted: Appeals may be conducted through an informal county procedure, the informal Agency process, the Quality Improvement Organization (QIO) or through the Division of Administrative Hearings (DOAH).

A. Appeals by the hospital when eligibility is denied may be made through the Administrative Appeals process or, informally, through an Agency hearing or a county-level hearings process.

B. If the Agency is acting as the certifying agency for the county, the county may not appeal the eligibility decision made by the Agency. However, if the county believes that the Agency is not determining eligibility correctly, the county must report this information to the Agency at the address specified in Chapter 1, Section 1-11.

C. Appeals by the hospital regarding the determination of the county residence may also be sent to the Agency address.

D. Appeals by the county regarding medical necessity and appropriateness of the services provided may be made to the QIO with which Medicaid has a contract for its outside utilization review or may be made through the formal administrative appeals process.

E. Appeals by the hospital regarding non-receipt of reimbursement from a county may be made through the administrative appeals process, an Agency informal hearing, or the informal county-level process.

7-4 Agency and DOAH Administrative Appeals: To request an informal Agency hearing or a formal DOAH hearing, the patient or the certifying agency must submit a request to:

Agency for Health Care Administration
Bureau of Central Services
Attn: HCRA Program
2727 Mahan Drive, Mail Stop Code 26
Tallahassee, Florida 32308

7-5 Request Format for an Informal Agency Hearing: The request should clearly identify who is appealing the action, what action is being appealed, the name and address of the agency that took the action, and the reason the requester believes the action is in error.

A. Appeal requests by a hospital or county regarding appropriateness of an admissions, length of stay, and medical necessity of the services do not go through the certifying agency. Instead, such requests are made directly to the PRO with which Medicaid has a contract for its outside utilization review. See Sections 7-8 and 7-9 for further information.

B. In appeal requests for other than reimbursement, the request may consist of a copy of the Notification of Eligibility and a memo stating when the request was received by the certifying agency.

C. Legal representation is not mandatory. It is not required that a lawyer represent either party at a hearing on an appeal.

D. The hearing officer's decision is binding on all parties.

7-6 Request Format for a Formal DOAH Hearing: The request for a formal DOAH hearing must meet the requirements of Florida Administrative Code, Section 28-5.201. For information regarding the formal DOAH hearing request, contact the agency office at the address specified in Section 7-4 of this Chapter.

7-7 Informal County-Level Appeals: Appeals regarding eligibility and/or reimbursement may be handled informally at the county level if the following conditions are met:

A. The hearing on the appeal is conducted at a reasonable time, date and place;

B. The party appealing the action is given an opportunity to examine the following at a reasonable time before and/or during the hearing:

   1. The contents of the case and/or fiscal records; and

   2. All documents and records to be used at the hearing by the agency that took the action.

C. The party appealing the action is given the opportunity to do the following:

   1. Bring witnesses,

   2. Establish all pertinent facts and circumstances,

   3. Present an argument without undue interference, and

   4. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

D. Both parties must be informed that the decision by the county hearing officer may be challenged through the administrative appeal process if either party does not agree with the county hearing officer's decision.

E. The hearing officer must be impartial.

F. A person involved in making the decision being appealed must not be the hearing officer on that particular case.

G. The decision of the hearing officer must be based on an independent review of the facts and on the administrative rules governing this program. This decision must be in writing and must include the following:

   1. A summary of the facts;

2. Identification of the administrative rules supporting the decision; and

3. A statement that if either party does not agree with the decision, a request for an administrative appeal may be made and the address to which such a request should be sent.

7-8 QIO Appeals: An appeal regarding the appropriateness of an admission, length of stay, and medical necessity of the services provided may be submitted to the QIO with which Medicaid has a contract for its outside utilization review. Please contact the Agency's Bureau of Central Services for the contact information.

7-9 Request Format for QIO Appeals: The format of the request must include the name and address of the county official requesting the appeal, the name and address of the hospital providing the service, the patient's name, admission date, discharge date or date emergency outpatient services were provided, medical record number, and a statement of why the county believes the services were inappropriate or unnecessary.

7-10 Appeal Reports: The county must complete Part III of the Monthly Caseload and Appeals Report informing the Agency of the status of such appeals. Instructions on how to complete this report are specified in Chapter 2, Section 2-7. A copy of the report is provided as Appendix B.

Adjudication: The official disposition made by the county on a claim submitted by a hospital for reimbursement. This disposition can be either an approval of a claim for payment or a denial with no payment.

Appeals: The request for a hearing due to denial of a claim or application.

Bureau of Central Services/Financial Analysis Unit: A unit within the Agency for Health Care Administration, Division of Health Quality Assurance, responsible for determining if hospitals have met their charity care requirements.

County Billing Agent: The person or office designated by the county to receive and process claims submitted by hospitals. In some counties, this person or office may also serve as the county financial office.

County Financial Office: The person or office in the county responsible for issuing the county's reimbursement check to a hospital. In some counties, this person or office may also serve as the county billing agent.

County of Residence: A specific county within the State of Florida where an individual establishes or maintains a living arrangement and which he/she, or someone responsible for him/her, considers to be his/her home with the intent to remain a resident of that county.

1. Such living arrangement cannot be a medical facility.

2. 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.

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

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

5. A student attending school away from home is considered a resident of the county in which his/her parents reside if he/her is claimed as a dependent for Federal Income Tax purposes.

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

45 Day Cap: The maximum combined number of days reimbursable under the Act per patient per county fiscal year for inpatient services and/or treatment.

Department: Department of Children and Family Services (DCF).

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.

d. If the dwelling place includes more than one family unit or more than one unrelated individual, the income and asset requirements are applied separately to each family unit or unrelated individual.

Maximum County Financial Responsibility: That amount obtained by multiplying the total county population by $4 per capita using the most recent official state population estimate for the total county population published by the Executive Office of the Governor. In 2001, the Legislature revised the Act to allow Agency to reduce the maximum amount that a county having a population of 100,000 or less may be required to pay. The Agency must reduce the official state population estimates by the number of inmates and patients residing in the county in institutions operated by the Federal Government, the Department of Corrections, the Department of Health, or the

Department of Children and Family Services, and by the number of active-duty military personnel residing in the county. A county is entitled to receive the benefit of this reduction only if the county accepts and does not require any re-verification of the documentation of financial eligibility and county residency provided to it by the participating hospital or regional referral hospital. The submitted documentation must be complete and in accordance with the requirements of Section 154.3105, Florida Statutes.

Outpatient $1,500 Cap: The maximum amount of reimbursement for outpatient services per patient during a county fiscal year.

Outpatient Reimbursement Rate: An inclusive rate of reimbursement calculated by the Agency for Health Care Administration for each category of a hospital's outpatient services provided.

Appendix B

HEALTH CARE RESPONSIBILITY ACT (HCRA)
MONTHLY CASELOAD AND APPEALS REPORT

County Fiscal Year _____

DIRECTIONS: Please complete and return by the 15th of the month following the month being reported to the Agency for Health Care Administration, Bureau of Central Services at: 2727 Mahan Drive, Mail Stop Code 26, Tallahassee, Florida 32308, Fax # (850) 487-6240, or via email to HCRA@ahca.myflorida.com . Please contact the HCRA liaison at (850) 412-4300 if you have any questions.

Please Print or Type

COUNTY NAME: _____ **REPORT MONTH:** _____

I. CASELOAD REPORT DISPOSITIONS	**OUT OF COUNTY**	**IN COUNTY**
1. Pending from prior Months		
2. Approvals During Report Month:		
3. Total applications received for the month		
4. Denials During Report Month, by Reason:		
a. Not a County Resident:		
b. Eligible for Medicaid or other government hospital reimbursement program:		
c. Exceeds Income Limitation:		
d. Exceeds Assets Limitations:		
e. Failure to Keep Appointment(s):		
f. Failure to Provide Information:		
g. Not a U.S. citizen or legally admitted alien:		
h. Resides in a public Institution:		
i. Has adequate insurance:		
j. Other (name): _____		
k. Other (name): _____		
5. Total Denials During Report Month:		
6. Pending at the End of the Report Month		

II. APPEALS DISPOSITIONS (both County Level and Administrative)		
1. Appeals Pending from the Month Previous to the Report Month:		
2. Appeals Received During the Report Month:		
3. Total Number of Appeals (sum II. 1. + II. 2.):		
4. Appeals Resolved During the Report Month:		
a. Action Up-Held:		
b. Action Overturned:		
5. Appeals Pending at the End of the Report Month:		

III. REPORT PREPARED BY:

Name of Staff: _____ Title: _____

Address: _____ Telephone #: (_____)_____

Signature: _____ Date: _____

INSTRUCTIONS FOR COMPLETING THE MONTHLY CASELOAD AND APPEALS REPORT

Out-of-County = applications from hospitals outside the reporting county

In-County = applications from hospitals within the reporting county

1. Pending from prior Months _____ = # of applications pending determination from previous months
2. Approvals During Report Month: _____ = # of applications approved during the reported month
3. Total applications received for the month _____ = # of applications received during the reported month
4. Denials During Report Month, by Reason:
   a. Not a County Resident: __# for current month
   c. Eligible for Medicaid or other government hospital reimbursement program: __# for current month
   c. Exceeds Income Limitation: __# for current month
   d. Exceeds Assets Limitations: __# for current month
   e. Failure to Keep Appointment(s): __# for current month
   f. Failure to Provide Information: __# for current month
   g. Not a U.S. citizen or legally admitted alien: __# for current month
   h. Resides in a public Institution: __# for current month
   i. Has adequate insurance: __# for current month
   j. Other (name): _enter reasons_____ __# for current month
   k. Other (name): __enter reasons_____ __# for current month
5. Total Denials During Report Month: _____ = Totals from 4a. through 4k.
6. Pending at the End of the Report Month _____ = (1. + 3.) – (2. + 5.) and this # will be carried over to line 1. on the next month's report.

II. APPEALS DISPOSITIONS (both County Level and Administrative)

1. Appeals Pending from the Month Previous to the Report Month: _____ = # of appeals from the previous month(s) still pending resolution
2. Appeals Received During the Report Month: _____ = # of appeals received during the reported month
3. Total Number of Appeals (sum II. 1. + II. 2.): _____ = 1. + 2
4. Appeals Resolved During the Report Month: _____ = # of appeals resolved during the reported month (equals 4a. + 4b.)
   a. Action Up-Held: _____ = # of decisions upheld for the reported month
   b. Action Overturned: _____ = # of decisions reversed for the reported month
5. Appeals Pending at the End of the Report Month: _____ = 3. – 4. and will be carried over to line II.1 on the next month's report

INSTRUCTIONS FOR COMPLETING THE QUARTERLY FINANCIAL REPORT

OUT-OF-COUNTY means claims filed by hospitals not in the reporting county.
IN-COUNTY means claims filed by hospitals from within the reporting county.

SPEND-DOWN PROVISION EXPENDITURES	Enter the dollar amount of spend-down claims paid for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
REGULAR EXPENDITURES	Enter the dollar amount of regular claims paid for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
TOTAL EXPENDITURES	The aggregate amount will automatically calculate
NO. OF SPEND DOWN CLAIMS PD	Enter the **number of** spend-down **claims paid** for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
NO. OF REGULAR CLAIMS PAID	Enter the **number of** regular **claims paid** for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
TOTAL CLAIMS PAID	The aggregate amount will automatically calculate
#OF SPEND-DOWN CLAIMS DENIED	Enter the number of spend-down claims denied for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
# OF REGULAR CLAIMS DENIED	Enter the number of regular claims denied for the respective quarter The aggregate amount will automatically calculate under the Fiscal Year Totals
TOTAL CLAIMS DENIED	The aggregate amount will automatically calculate

HEALTH CARE RESPONSIBILITY ACT (HCRA)
- COUNTY FISCAL YEAR QUARTERLY FINANCIAL REPORT

Please complete and return to the address below within 30 calendar days of the end of each quarter.

THE EXPENDITURES REPORTED ON CLAIMS PAID SHOULD ONLY REFLECT THOSE CLAIMS WITH A DATE OF SERVICE DURING THE SPECIFIED COUNTY FISCAL YEAR

HCRA EXPENDITURES OUT / IN-COUNTY	1st QRT OCT - DEC		2nd QTR JAN - MAR		3rd QTR APR - JUN		4th QTR JUL - SEP		FISCAL YEAR TOTALS	
	OUT-COUNTY	IN-COUNTY	OUT-COUNTY	IN-COUNTY	OUT-COUNTY	IN-COUNTY	OUT-COUNTY	IN-COUNTY	OUT-COUNTY	IN-COUNTY
SPEND-DOWN EXPENDITURES 0									$0.00	$0.00
REGULAR EXPENDITURES 0									$0.00	$0.00
TOTAL EXPENDITURES 0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
# OF SPEND-DOWN CLAIMS PAID									0	0
# OF REGULAR CLAIMS PAID									0	0
TOTAL CLAIMS PAID	0	0	0	0	0	0	0	0	0	0
#OF SPEND-DOWN CLAIMS DENIED									0	0
# OF REGULAR CLAIMS DENIED									0	0
TOTAL CLAIMS DENIED	0	0	0	0	0	0	0	0	0	0

Attach copies of all claims paid indicating the allowable amount through HCRA and proof of payment for each claim paid during the reported quarter. Submit this completed report form and supporting documentation to the: Agency for Health Care Administration, Bureau of Managed Health Care, 2727 Mahan Drive, Mail Stop 26, Tallahassee, FL 32308. Please contact the HCRA liaison via email at HCRA@ahca.myflorida.com if you have any questions.

REPORT COMPLETED BY: _____ (Name of Preparer - please print or type) _____ (Signature) _____ (Date)

COUNTY: _____ _____ (Title) _____ (Mailing Address)

_____ (City & State) _____ (Zip Code) Telephone: _____ Fax: _____

NOTES:

HEALTH CARE RESPONSIBILITY ACT (HCRA)
OUT-OF-COUNTY PATIENTS - CHARITY WRITE OFFS

Please provide information based upon your hospital's most recent fiscal year end report. Return by July 31st of the current year, to Agency for Health Care Administration, Bureau of Central Services, Financial Analysis Unit, 2727 Mahan Drive, Mail Stop Code 28, Tallahassee, Florida 32308. Directions are provided on the back of this document. This form is used to determine your hospital's statewide eligibility for the upcoming county fiscal yea (Oct. 1 - Sep 30) HCRA. This form is for informational purposes only.

HOSPITAL NAME:_____ **HCB HOSPITAL #:**_____ **FISCAL YEAR ENDDATE:** _____

OFFICIAL COMPLETING THIS REPORT:_____ **OFFICIAL'S SIGNATURE:**_____
(please print or type)

PHONE #: (__) _____

PATIENT NUMBER	DATE OF SERVICE/ DISCHARGE	TOTAL PATIENT CHARGES	CHARITY CARE WRITTEN OFF HILL BURTON	CHARITY CARE WRITTEN OFF OTHER	DATE ACCOUNT WRITTEN OFF	PATIENT'S RESIDENCE CITY	PATIENT'S RESIDENCE COUNTY	DOCUMENTATION SUPPORTING THE PATIENT'S COUNTY RESIDENCE
TOTAL:								

PAGE ___ **OF** ____

IF YOU HAVE QUESTIONS, PLEASE CALL THE FINANCIAL ANALYSIS UNIT AT (850) 412-3951.

(OVER)

INSTRUCTIONS FOR COMPLETION OF
HCRA OUT-OF-COUNTY PATIENTS REPORT - CHARITY CARE WRITE-OFFS

PLEASE PROVIDE ALL THE INFORMATION REQUESTED BELOW FOR EACH CHARITY CARE PATIENT LISTED; OTHERWISE, THIS REPORT WILL BE RETURNED TO YOU FOR COMPLETION AND RE-SUBMISSION.

1. CHARITY CARE WRITTEN OFF: Report only dollar amounts for each patient. If the amount written off exceeds the patient's charges, please provide an explanation.

2. DATE ACCOUNT WRITTEN OFF: Report for only those patients whose accounts were written off during the fiscal year which corresponds to the hospital fiscal year currently being reported.

3. PATIENT'S RESIDENCE: Report the city and county of residence only for each charity care patient who does not reside in the same county in whic your hospital is located. Out-of-state patients may be included in this report; for any out-of-state patients, please report state of residence in place of county residence.

4. DOCUMENTATION SUPPORTING THE PATIENT'S COUNTY OF RESIDENCE: Provide a description of the type of document used to verify t patient's residence. The AHCA will accept the following types of documents as acceptable forms of documentation to support residency:

a. Driver License

b. Mortgage, lease or 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 family unit member to a residential address within the county

e. A state, county, or federal document mailed to the applicant to a residential address within the county

f. Vehicle registration in the name of the applicant or family unit member to a residential address within the county

g. Voter's registration

h. Proof children/spouse/patient are enrolled in public schools/colleges within the county

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

j. A statement signed by the patient or his legal guardian or designated representative attesting to the patient's county of residence

Appendix E

SAMPLE AGREEMENT

HEALTH CARE RESPONSIBILITY ACT
AGREEMENT TO PROVIDE EMERGENCY MEDICAL SERVICES
BETWEEN

Hospital:_____
and

County:_____

In order to meet the hospital participation requirements under the Health Care Responsibility Act, F.S. 154 and Administrative Rule 59H-1, this agreement is entered into between _____, hereinafter referred to as the "hospital" and _____ County of Florida, hereinafter referred to as the "county."

A. The Hospital Agrees:

1. To provide emergency inpatient and outpatient hospital care to county residents who are deemed indigent and who qualify for assistance under the Health Care Responsibility Act.

2. To comply with the statute, rules, policies, procedures and other provisions outlined by the Health Care Responsibility Act.

B. The County Agrees:

1. To determine eligibility and reimburse the hospital in accordance with the Health Care Responsibility Act.

2. To reimburse the hospital at _____ percent of the hospital's Medicaid inpatient and outpatient per diem rates in effect at the time hospital services are rendered to county residents qualified for assistance under the Health Care Responsibility Act.

3. To send payments to:

"Insert Hospital's Name and Mailing Address"

C. It is Mutually Agreed that:

1. This agreement shall begin on _____ and continue in effect until renegotiated or terminated.

2. This agreement may be terminated at will and without cause by either party, upon no less than 30 days notice. Said notice shall be delivered by certified mail or in person.

For the Hospital:

_____
(signature)

_____
(name - type or print)

_____ _____
(title) (date)

For the County:

_____
(signature)

_____
(name - type or print)

_____ _____
(title) (date)

State of Florida, Agency for Health Care Administration

NOTIFICATION OF ELIGIBILITY FOR HEALTH CARE ASSISTANCE

NOTE: THIS FORM IS NOT PROOF OF ELIGIBILITY FOR MEDICAID

Resident County: _____

Name and Address of Office Making Determination:

_____
Applicant Name

_____
Street Address

_____
Date Mailed

_____
City, State, Zip Code

_____
Case Number

_____
Hospital Name

_____
Patient Account Number

Only the Items where the ☐ has an "X" apply to you. The action(s) checked below is being taken in accordance with Florida Statutes, Chapters 154 and/or 409, and Florida Administrative Code, Sections 59H-1.0035 through 59H-1.015.

☐ You have been found eligible for medical assistance under the Health Care Responsibility Act. This will provide payment for hospital care services provided to you for services beginning on _____, up to the maximum services provided by law, subject to the availability of program funds. Under the spend-down provision, your share of costs is $_____.

☐ Your application for medical assistance under the Health Care Responsibility Act has been denied for hospital care services provided to you beginning on _____ based on Florida Administrative Code Rule Number(s):

_____

Reason(s):

_____

If you have a reason to believe that this action is incorrect, your worker will be glad to discuss it with you; and, the hospital has the right to request a hearing before a hearings officer. A request for a hearing should be made within 90 days from the date at the top of this notice. The address and telephone number of your local office are shown on this form.

By: _____ Telephone Number: _____

(printed name)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true a correct copy of the foregoing has been furnished to the applicant at the above mentioned address via regular ground mail and to the above mentioned hospital via☐ fax,☐ email, and/or☐ regular ground mail on _____.

(date)

_____

(Signature)

Summary of Florida Administrative Rules Governing Eligibility Under the Health Care Responsibility Act (HCRA).

Factor	HCRA Rule	Summary
Adequate Insurance	59H-1.0035(2)	An Applicant must have no or inadequate insurance to qualify.
Application Submission Date	59H-1.008(3)	Applications must be sent to the certifying agency with 30 days of admission or treatment.
Availability of Program Funding	59H-1.0045	When all funds allocated for the program are expended, no reimbursement will be made to the hospital.
Assets	59H-1.0035(6)	Assets may not exceed specified limits.
County Residence	59H-1.009	The applicant must be a resident of the county to which the application is submitted.
Covered Services	59H-1.0065	Emergency Medical Treatment, Non-emergency if services are not available in county with funding.
Provision of Information by Applicant	59H-1.015(2)	The applicant or designated representative must provide information requested by the certifying agency and must keep scheduled appointments.
Income	59H-1.008(8)	Applicants must have gross income less than 100% of the poverty level, or spend-down less than 150%.
Other Program Eligibility	59H-1.0035(30)	Applicants must not be eligible for other government medical assistance programs.
Participating Hospitals	59H-1.0055	Reimbursement can only be made for covered services provided by a participating hospital.
Eligible Applicant	59H-1.0035(30)	An applicant must meet the income, assets, residence requirements to qualify.

SCS ☐ HCRA ☐

State of Florida, Agency for Health Care Administration

HEALTH CARE ASSISTANCE APPLICATION

In-County ____ Out-of-County ____

Applicant's County of Residence ____________

PART 1 - HOUSEHOLD INFORMATION - To Be Completed By Applicant

Name: First, Middle, Last	Date of Birth	Relationship to Applicant	Health Insurance or 3rd Party Coverage	Blind	Disabled	Pregnant	Agency Referred To
		PATIENT	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Living Address: | Mailing Address: | Previously Hospitalized in Florida in Last Year? ☐ Yes ☐ No | If yes, Where:

Phone Number: ( ) | Shelter Situation: ☐ Rent ☐ Buy ☐ Own ☐ Other | U.S. Citizen? ☐ Yes ☐ No | Alien Regisgration No.:

PART 2- FINANCIAL INFORMATION - To Be Completed By Applicant

INCOME EXAMPLES	INCOME TYPE	WHO HAS	GROSS AMOUNT	HOW OFTEN	ASSETS EXAMPLES	TYPE	WHO HAS	VALUE
Wages, Self-Employment,			$		Cash, Checking account, Car/truck,			$
Social Security, Child Support			$		Motorcycle, Burial insurance, Trust			$
Contributions, Unemployment			$		funds, Life insurance, Burial plot,			$
Compensation, Railroad			$		Real estate, Business equipment,			$
Retirement, SSI, AFDC			$		Boat, Stocks/Bonds, Savings			$
		TOTAL INCOME	$				TOTAL ASSETS	$

PART 3 - DECLARATION

I am applying for assistance. I understand that, in addition to completing this form, I may have to provide accurate sources of information and verification in regards to eligibility requirements. I understand I may be asked for an interview and am expected to keep appointments. I agree to apply for any other medical assistance program I may be eligible for. I authorize release of such eligibility determination information to the certifying agency as deemed necessary in connection with my application. I understand that I may have a share of cost that I will be responsible to pay to the hospital. It could be a crime if I am not truthful about my eligibility for assistance. Should it be determined that fraud was committed or incorrect information was intentionally provided, resulting in an inappropriate eligibility determination, I will be responsible for repaying any amounts paid on my behalf.

Signature ____ Date ____ Spouse's or Representative's Signature ____ Date ____

PART 4- PATIENT INFORMATION - To Be Completed by Hospital Personnel

Date Admitted or Services Provided: | Date of Discharge: | Patient Account No.: | Deceased: Yes ☐ No ☐ Date:

Case Mgmt. Agency: | ☐ Enrolled ☐ Referred Date: | Previously Hospitalized in this hospital in Last Year? Yes ☐ No | If yes, When: | InPatient: / OutPatient $ | # Days / Total Charge

PART 5 - REFERRAL HOSPITAL - To Be Completed By Hospital Personnel

Referral Hospital: ____________ Hospital HCRA ID #: ______

Address: ____________ Date Sent To County: ______

Signature: ____________

Print Name: ____________ Phone Number: ( )

Charity Obligation Met? Yes ☐ No ☐

PART 6 - COUNTY/AGENCY USE

WORKER:

Name

Phone Number

Application Approved: Yes ☐ No ☐

DATE STAMP

AHCA Form 5220-0001, February 2016

Section 59H-1.0035(20), Florida Administrative Code

Form available at: http://www.ahca.myflorida.com/MCHQ/Central_Services/Financial_Ana_Unit/HCRA/index

INSTRUCTIONS TO PATIENT/APPLICANT

- We would like you to fill out as much of Part 1 and Part 2on the front as you can. If you cannot fill it out, a hospital worker will help you.
- In Part 1, list your name first and then list the names of all relatives that live with you.
- DO NOT write in Parts 4, 5, and 6. These are for office use only. DO NOT write on the back of this form.
- In order for this form to count as an application for assistance in paying your hospital bill, you must read, sign and date Part 3 on the front. Be sure to fill in your address so we can contact you about an interview should we need to request additional information.
- Return ALL COPIES of this form to a hospital staff person.

INSTRUCTIONS TO HOSPITAL WORKER

- Complete Part 1 and Part 2 for the patient/applicant unless the patient/applicant wants to do it.
- Assist the patient/applicant in obtaining all necessary vertifications.
- Give the YELLOW copy of the form to the patient/applicant.
- Complete Part 4 and Part 5. Sign Part 3 if the patient is unable to sign or if the hospital is acting as the patient's representative.
- Send the WHITE copy to the certifying agency for processing with all verification obtained.
- Retain the PINK copy for your records.

INSTRUCTIONS TO CERTIFYING AGENCY

- Date stamp in Part 6 upon receipt.
- Determine whether all necessary verification has been provided.
- Schedule an interview with the patient/applicant to obtain additional information if necessary.
- Determine eligibility.
- Notify patient/applicant and referring hospital of decision.

1	2	3a PAT. CNTL # / b. MED. REC. #	4 TYPE OF BILL
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME a / b	9 PATIENT ADDRESS a / b / c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 CODE / DATE	32 CODE / DATE	33 CODE / DATE	34 CODE / DATE	35 CODE / OCCURRENCE SPAN FROM / THROUGH	36 CODE / OCCURRENCE SPAN FROM / THROUGH	37

38	39 CODE / VALUE CODES AMOUNT	40 CODE / VALUE CODES AMOUNT	41 CODE / VALUE CODES AMOUNT
	a		
	b		
	c		
	d		

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI / 57 OTHER PRV ID	
A								A
B								B
C								C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	67 I	A	B	C	D	E	F	G	H	68
		J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX a / b / c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE / DATE	a OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

80 REMARKS	81CC a / b / c / d	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

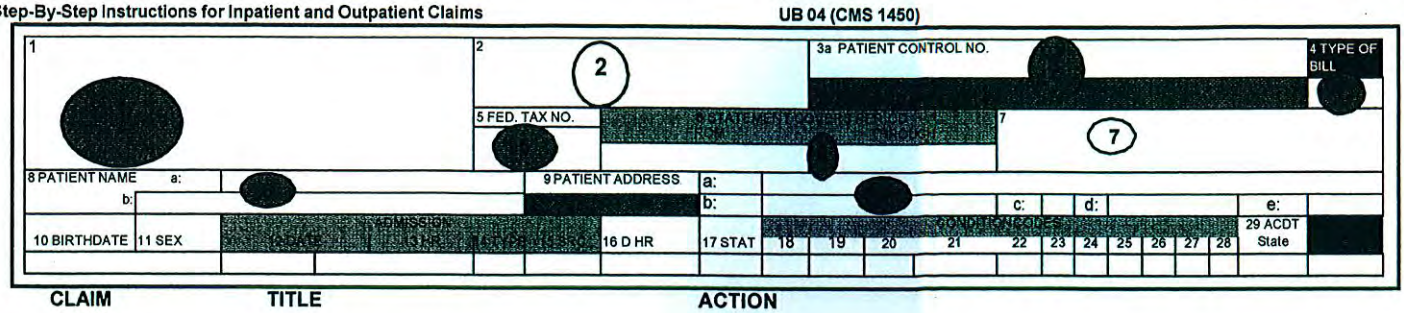
UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

NUBC National Uniform Billing Committee

LIC9213257

Step-By-Step Instructions for Inpatient and Outpatient Claims **UB 04 (CMS 1450)**



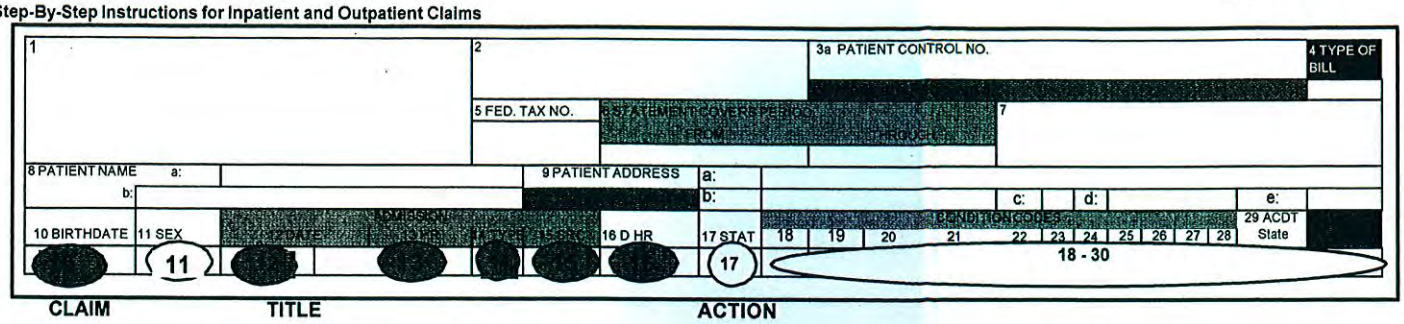
CLAIM ITEM	TITLE	ACTION
1 Required	Provider Name, Address, and Telephone Number	The minimum entry is the provider's name, city, state, and zip code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine digit zip codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or fax numbers are desirable.
2	Unititled	
3 Required	Patient Control Number	The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.
4 Required	Type of Bill	This four-digit alphanumeric code gives three specific pieces of information after the leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

The first Digit is a Zero

2nd Digit - Type of Facility	3rd Digit - Classification	4th Digit - Frequency
1 - Hospital	1 - Inpatient	1 - Admit through Discharge Claim
2 - Skilled Nursing	2 - Hospital Based or Inpatient	2 - Interim - First Claim
3 - Home Health	3 - Outpatient	3 - Interim-Continuing Claims
4 - Religious Non-Medical (Hospital)	4 - Other	4 - Interim - Last Claim
5 - Reserved for National Assignment (discontinued 10	5 - Intermedicate Care - Level I	5 - Late Charge Only
6 - Intermediate Care	6 - Intermedicate Care - Level II	7 - Replacement of Prior Claim
7 - Clinic or Hospital Based Renal Dialysis Facility	7 - Reserved for National Assignment (discontinued 10/1/05)	
8 - Special Facility or Hospital ACS Surgery	8 - Swing Bed	8 - Void/Cancel of a Prior Claim
9 - Reserved for National Assignment	9 - Reserved for National Assignment	9 - Final Claim for a Home Health PPS

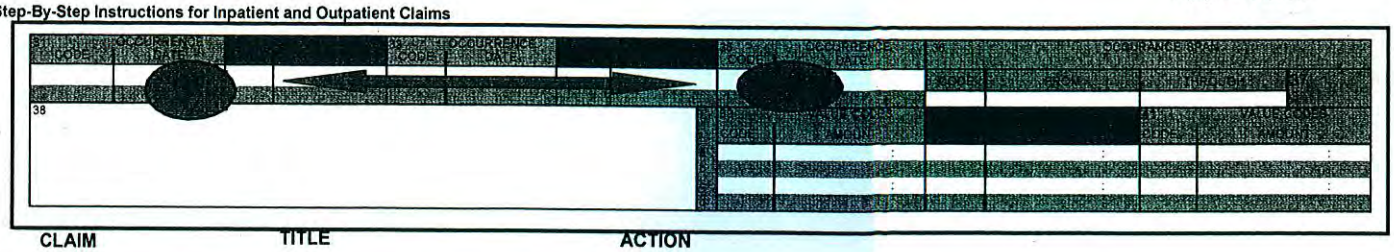
5 Not Required	Federal Tax Number	Entry not required, but desirable.
6 Required	Statement Covers Period (From-Through)	The beginning and ending dates of the period included on this bill are shown in numeric fields (MM-DD-YYYY). Days before the patients' entitlement are not shown. Use the "From" date to determine timely filing. For all services received on a single day, enter both the "From" and "Through" dates using the same date for both items. **Inpatient:** Inpatient claims for dates of services which span the end of the month of September into the month of July **MUST** be split billed as follows: 1. For the first bill, enter the discharge date as 10/1/YYYY. Be sure to bill only for those services supplied through this date. 2. For the second bill, enter the actual admission in Item 17, but list 10/1/YYYY as the "From" date in Item 6. Bill only for those services supplied after 10/1/YY.
7	Untitled	
8 Required	Patient's Name	Enter Patient's first and last name
9 Required	Patient's Address	Enter Patient's full address. "a, c, d," = living address "b,c,d" = Mailing address if different than living address

Step-By-Step Instructions for Inpatient and Outpatient Claims



CLAIM	TITLE		ACTION
10 Required	**Birthdate**		Enter the Patient's date of Birth Use the month, day and year of birth - MMDDYYYY - if unknown use zeros for all eight digits
11 Not Required	**Sex**		No entry required for HCRA.
12 Required	**Admission Date**	**Inpatient:** **Outpatient:**	The month, day, and year of admission is shown numberically as MM/DD/YYYY. for January 11, 1999. No entry required
13 Required	**Admission Hour**		For Inpatient enter the hour patient was admitted
14 Required	**Type of Admission**	**Inpatient:** **Outpatient:**	Enter the code number indicating the type of admission from the code structure below: **1. - Emergency:** The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room. **2. - Urgent:** The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodations. **3. - Elective:** The patient's condition permits adequate time to schedule the availability of a suitable accommodation. **5 - Trauma Center:** Visits to a trauma center/hospital as licensed by or authorized by the State to be a trauma center. **9. - Information Not Available:** The hospital cannot classify the type of admission. This code is rarely used. No entry is required.
15 Required	**Source of Admission**	**Code Structure:**	This is the code indicating the source of this admission or outpatient registration. For Emergency, Elective or Other Type of Admission. **1. - Physician Referral: Inpatient:** The patient was admitted upon the recommendation of a physician. **Outpatient:** Referred for outpatient or diagnostic services by physician or self-referral. **2. - Clinic Referral:** The patient is admitted upon the recommendation of the facility's clinic physician. **3. - Managed Care Plan Referral:** The patient is admitted upon the recommendation of a managed care organization. **4. - Transfer from a Hospital:** The patient is admitted as a transfer from an acute care facility where he/she was an inpatient. **5. - Transfer from a SNF:** The patient was admitted as a transfer from a SNF where he/she was an inpatient. **6. - Transfer from Another Facility:** The patient was admitted to the facility as a transfer from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a nonskilled level of care. **7. - Emergency Room:** The patient was admitted upon the recommendation of the facility's emergency room physician. **8. - Court/Law Enforcement:** The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's representative. **9. - Information Not Available:** The means by which the patient was admitted is not known.
16 Required	**Discharge Hour**		Enter the time of discharge using the following format: hh:mm a.m. or hh:mm p.m.
17 Required	**Patient Status**	**Inpatient:** **Outpatient:**	Enter the code indicating patient status as of the discharge date (or last date billed in the case of interim billing). **PATIENT STATUS CODES:** **1** - Discharged to home or self care (routine discharge). **2** - Discharged/transferred to another short-term general hospital. **3** - Discharged/transferred to a skilled nursing facility (SNF). **4** - Discharged/transferred to an intermediate care facility (ICF). **5** - Discharged/transferred to another type of institution or referred for outpatient services to another institution. **6** - Discharged/transferred to home under care of organized home health service organization. **7** - Left against medical advice or discontinued care. **8** - Reserved for National Assignment **10-19** Reserved for National Assignment **20** - Expired (or did not recover - Religious Non Medical Health Care Patient) **30** - Still a patient or expected to return for outpatient services **09** - Admitted as an inpatient to this facility. Otherwise, no entry is required.
18 - 28 Not Required	**Condition Codes**		No Entry is required for HCRA
29 Not Required	**Accident State**		No entry required for HCRA.
30 Untitled			

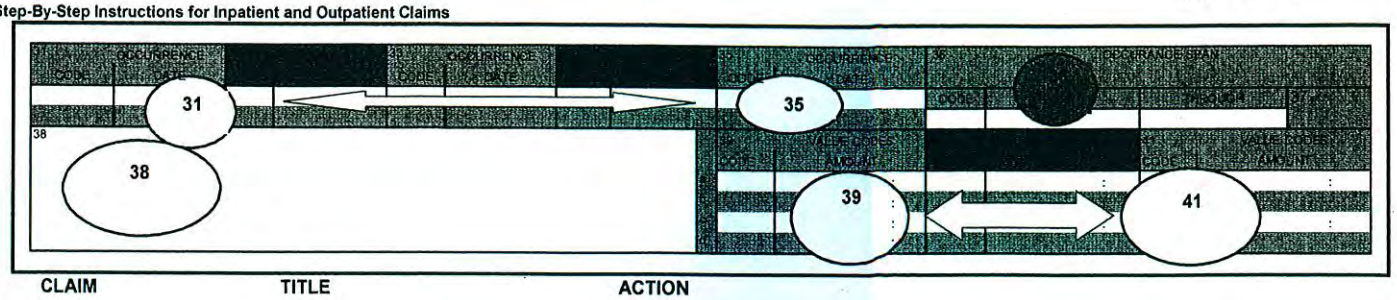
Step-By-Step Instructions for Inpatient and Outpatient Claims



CLAIM ITEM	TITLE	ACTION
31 - 35 Required	**Occurrence Code and Dates**	**Inpatient and Outpatient:** Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Item 32A. If more than one code and date are used, they must be entered in Items 32A through 35B in chronological order. Enter the date in month, day, year format: MM/DD/YYYY

Code	Title	Definition
1	Accident/Medical Cover	Used to report an auto accident that involves liability insurance.
2	No-Fault Insurance Involved - Including Auto Accident/Other	Accident-related injury for which there is medical payment coverage. Provide date of accident/injury. Sate of an accident where the State has applicable no-fault or liabilty laws.
3	Accident/Tort Liability	Accident resulting from a third party's action(s) that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability. Provide date of accident
4	Accident/ Employment Related	Date of an ccident relating to the patient's employment.
5	Accident/No Mecical or Liability Coverage	Accident not described by the above codes. Used to report that the provider has developed for other casualty related payers and has determined there are none. Provide date of accident.
6	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
11	Onset of Symptoms or Illness	Code indicates date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	The patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit.
16	Date of Last Therapy	Code indicates the last day of therapy services, physical, occupational or speech.
17	Date Occupational Therapy Plan Established or Reviewed	The date a plan was established or last reviewed for occupational therapy
18 - 21		Medicare Related - Not HCRA usable
22	Date Active Care Ended	Date on which a covered level of care ended in a SNF. Code is not required if code 21 is used.
24	Date Insurance Denied	The date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	The date on which coverage is no longer available to the patient.
26	Date SNF Bed Available	Date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27 - 30		Medicare Related - Not HCRA usable
31	Date of Beneficiary Notified of Intent to Bill (Accommodations)	Date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	Medicare Only - Treatment or procedures not considered reasonable or necessary by Medicare.
33 - 34		Medicare Related - Not HCRA usable
35 - 46		Used for Medicare related services, i.e., physical, occupational or speech therapy, hospice, cardiac rehab., etc.
47 - 49	Payer Codes	Reserved for internal use only by third party payers. HCFA assigns as needed, providers do not report them.
50 - 69		Reserved for State Assignment.
A1	Birthdate-Insured A	The birthdate of the insured in whose name the insurance is carried.
A2	Effective Date - Insured A Policy	Indicates the first date the insurance is in force.
A3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer A.
B1	Birthdate -Insured B	The birthdate of the insured in whose name the insurance is carried.
B2	Effective Date - Insured B Policy	Indicates the first date the insurance is in force.
B3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate -Insured C	The birthdate of the insured in whose name the insurance is carried.
C2	Effective Date - Insured C Policy	Indicates the first date the insurance is in force.
C3	Benefits Exhausted	The last date for which benefits are available and after which no payment can be made to payer C.

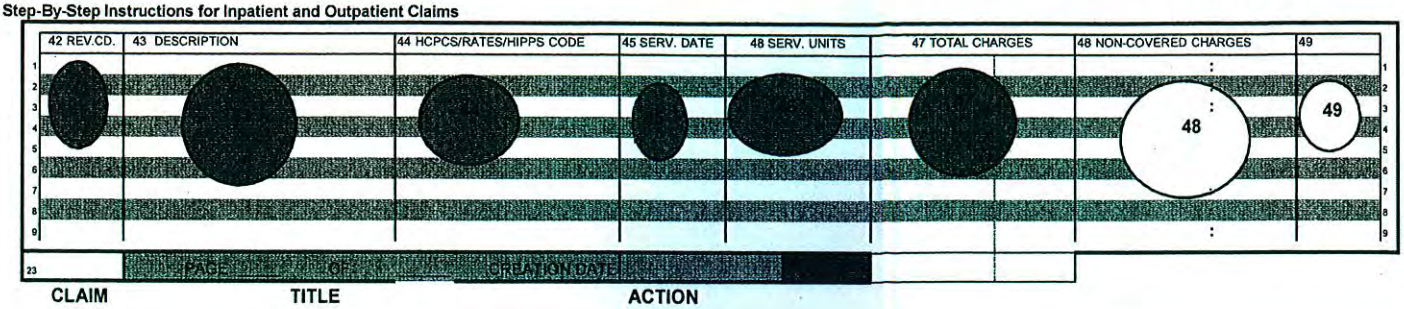
Step-By-Step Instructions for Inpatient and Outpatient Claims



CLAIM ITEM	TITLE	ACTION
36 Required IF:	Occurrence Span Code and Dates	Enter codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYYYY.
37	Untitled	
38 Not Required	Responsible Party Name and Address	Entry not required
39 - 41 A, B, C, D Not Required	Value Codes and Amounts	Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. Negative amounts are not allowed except in Item 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Required only for Medicare/Medicaid crossovers.

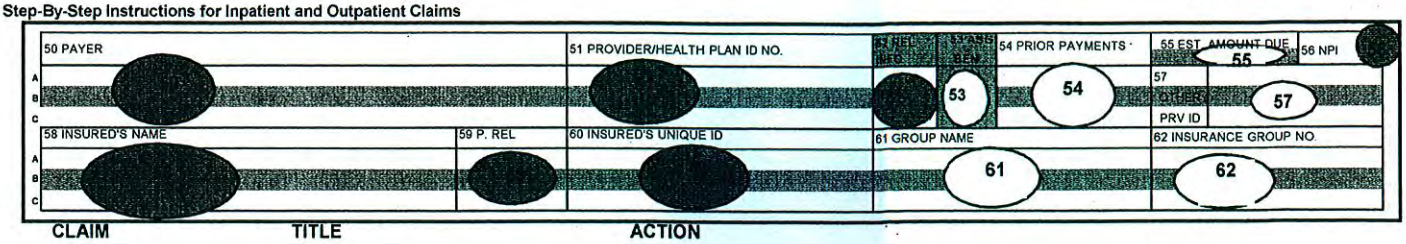
Code	Title	Definition
4	Inpatient Professional Component Charges Which are Combined Billed	The amount shown is the sum of the inpatient professional component charges which are combined billed. Used only by all-inclusive rate hospitals.
5	Professional Component Included in Charges and Also Billed Separately to Carrier	The charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the carrier.
6 - 13		Medicare exclusive codes.
14	No-Fault, Including Auto/Other Insurance	Amount shown is that portion of a higher priority no-fault, including auto/other, insurance payment made on behalf of a patient that the provider is applying to the covered HCRA charges on the bill.
15 - 19		Other government programs, not including HCRA.
31	Patient Liability Amount	The amount shown is that which was approved by the PRO to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
37 - 46, 48 & 49		Medicare exclusive codes.
47	Any Liability Insurance	Amount is that portion from a higher priority liability insurance made on behalf of the patient that the provider is applying to covered HCRA services on the bill
50 - 57 and 60		These codes are not money amounts but represent the number of home care visits.
58 - 79		Medicare exclusive codes - not usable with HCRA
A1	Deductible Payer A	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
B1	Deductible Payer B	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
C1	Deductible Payer C	Amount assumed by the provider to be applied to the patient's deductible amount invilving the indicated payer.
A2	Coinsurance Payer A	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	Amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	Amount estimated by the provider to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	Amount estimated by the provider to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	Amount estimated by the provider to be paid by the indicated payer.
D3	Estimated Responsibility - Patient	Amount estimated by the provider to be paid by the indicated patient.
A4	Covered Self-Administrable Drugs Emergency	Amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (Insulin is the only covered charges for an ordinarily non-covered, self-administered drug administered to a patient in a diabetic coma.)

Step-By-Step Instructions for Inpatient and Outpatient Claims



CLAIM ITEM	TITLE	ACTION
42 Required	Revenue Code	**Inpatient and Outpatient:** Enter the appropriate three-digit revenue code itemizing all accommodations and ancillary charges. "General Classification" revenue codes are acceptable. Indicate the total amount of all revenue codes billed in Item 47 accompanied by revenue code "001" in Item 42. Appendix P lists the revenue center codes for inpatient and Appendix Q lists the revenue codes for outpatient hospital services. (Appendix P and Q referrs to the HCRA Handbook) Each applicable revenue code should be used only once per UB-04 invoice, EXCEPT for revenue codes in the 300 - 319 range with different LCPCS codes used on outpatient claims. Each revenue code in the 300 -319 range billed on outpatient claims MUST have an accompanying LCPCS code in Item 44. (See list in HCRA Handbook, Appendix Q for Lab Codes.) Outpatient professional component charges (revenue code range 960 - 989) are not billable on the UB-04. Bill these services on the HCFA-1500 according to guidelines in the Physician Handbook.
43 Required	Revenue Description	**Inpatient and Outpatient:** Enter a written description of the related revenue categories included on this bill. This information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.
44 Required IF	HCPCS / Rates HIPPS CODE	Entry required for Revenue Codes 300 - 319 for HCRA
45 Required IF Outpatient	Service Date	For outpatient claim providers, report a separate date for each day of service.
46 Required	Service Units	The entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. Providers have been instructed to provide the number of covered days, visits, treatments, and tests applicable for the following: Accommodations - 100s-150s, 200s, 210s (days) Blood - 380 (pints) DME - 290s (rental months) Emergency room visits - 450, 0452 and 0459 (HCPCS code for visit or procedure) Clinic visits - 510s and 520s (visits) Dialysis treatments - 800s (sessions or days) Orthotic/prosthetic devices - 0274 (items) Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (visits) Outpatient clinical diagnostic laboratory tests - 30s-31s (tests) Radiology - 32X, 34X, 35X, 40X, 61X, and 333 (tests or services) Oxygen - 600s (rental months, feet or pounds) Hemophilia blood clotting factors - 636 Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.
47 Required	Total Charges	The total charges for the billing period are summed by revenue code (Item 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and entered on the adjacent line in Item 47. The last revenue code entered in Item 42 is "0001" which represents the grand total of all covered and non-covered charges billed. Item 47 totals on the adjacent line. Each line allows up to nine numeric digits. **For outpatient billing**, only charges believed to be covered are submitted in Item 47. Non-covered charges are omitted from the bill.
48 Not Required	Non-Covered Charges	**Inpatient:** No entry required. **Outpatient:** Enter the total payment received or expected to be received from a primary insurance payer identified in Item 50A. Enter each portion of the payment applicable to each code in Item 48. If there is more than one other private payer, lump all amounts together in Item 48 and attach each company's Explanation of Benefits or remittance.
49	Untitled	
Line 23 Required On All Pages	Page____of_____ Creation Date Totals	Enter the page numbers, example: Page 1 of 1, Page 1 of 2, etc. Enter the date UB 04 was completed Enter the total amount of Item 47

Step-By-Step Instructions for Inpatient and Outpatient Claims

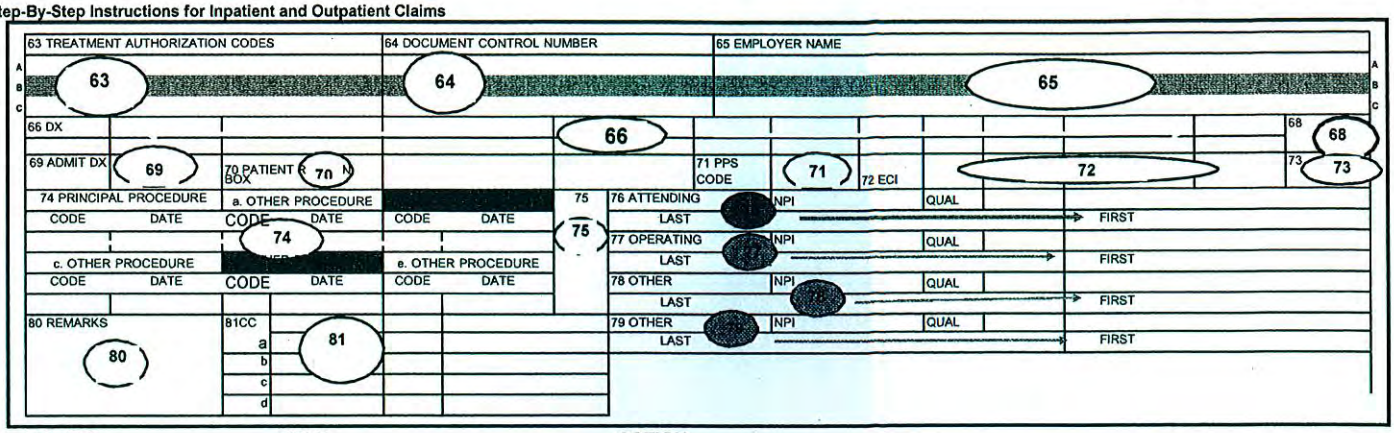


CLAIM ITEM	TITLE	ACTION
50 A, B, C Required	Payer Identification	**Inpatient and Outpatient** Enter the name and, if required, number identifying each payer organization from which the provider might expect some payment for the bill.
51 A, B, C Required	Provider or Heatlh Plan ID Number	Report the national health plan identifier when one is established otherwise report the "number" FL Medicaid has assigned
52 A, B, C Required	Release of Information	A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file. **NOTE:** The back of the UB-04 CMS-1450 contains a certification that all necessary release statements are on file.
53 A, B, C Not Required	Assignment of Benefits Certification Indicator	No entry required.
54 A, B, C Not Required	Prior Payments	For all services <u>other than inpatient hospital and SNF services</u>, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.
55 A, B, C Not Required	Estimated Amount Due	No entry required.
56 Required	National Provider ID - NPI	Required as of May 23, 2007
57 Not Required	Other Provider ID	No entry required.
58 A, B, C Required	Insured's Name	**Inpatient and Outpatient: Enter if another payer paid some of the charges.** Enter the insured's last name, first name, and middle initial. If the recipient is covered by insurance enter the name of the individual in whose name the insurance is covered.
59 A, B, C Required if Item 58 is completed.	Patient's Relationship to Insured	If the provider is claiming a payment under Item 58, it may enter the code indicating the relationship of the patient to the identified insured if this information is readily available.

Code	Title	Definition
01	Spouse	Self-explanatory
18	Self	Self-explanatory
19	Natural Child/Insured has Financial Responsibility	Self-explanatory
20	Employee	Self-explanatory
21	Unkown	Self-explanatory
39	Organ Donor	Code is used in cases where a bill is submitted for care given to an organ donor where it is paid by the receiving patient's insurance coverage.
40	Cadaver Donor	Code is used where a bill is submitted for procedures performed on a cadaver donor where they are paid ge. by the receiving patient's insurance covera
53	Life Partner	Patient is claiming insurance as a result of injury covered by insured.
G8	Other Relationship	

60 A, B, C Required	Insured's Unique ID	**Inpatient and Outpatient:** Enter all of the insured's unique identification numbers assigned by any payer organizations.
61 A, B, C Not Required	Group Name	No entry required Where the provider is claiming a payment under Item 58, enter the name of the insurance group or plan.
62 A, B, C Not Required	Insurance Group Number	No entry required. Where the provider is claiming a payment under Item 58, enter the identification number, control number, or code assigned by such health insurance carrier.

Step-By-Step Instructions for Inpatient and Outpatient Claims



CLAIM ITEM	TITLE	ACTION
63 A, B, C Not Required	Treatment Authorization Code	Whenever PRO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, the authorization number is required for all approved admissions or services. If you get a pre-approval for HCRA - you can indicate that here
64 Not Required	Document Control Number	Entry not required for HCRA
65 Not Required if not employed	Employer Name	Inpatient and Outpatient: Enter the name of the employer that might or does provide health care coverage for the patient in relation to Item 58.
66 Not Required	Diagnosis and Procedure Code Qualifier	Not required for HCRA
67 Missing from form		
68	Untitled	
69 Not Required	Admitting Diagnosis	No entry required for HCRA
70 Not Required	Patient Reason for Visit	No entry required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. Patient's Reason for Visit may be used by providers for non scheduled visits for outpatient bills
71 Required	Prospective Payment System (PPS) Code	Inpatient: APR-DRG code (must be 4-digits)
72 Not Required	External Cause of Injury (ECI) Codes	No entry is required. Not used
73	Untitled	
# 74 Not Required	Principal Procedure Code	Inpatient: The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (Item 67). The procedure code shown must be the full ICD-9-CM procedure code including all four digit codes where applicable. The date applicable to the principal procedure is shown numerically as MM/DD/YYYY.
a, b, c, d, e,	Other Procedure Code	Inpatient: The full ICD-9-CM procedure codes including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure, Item 80. The date of each procedure is shown in the date portion of Item 81, if applicable, as MM/DD/YYYY.
75	Untitled	
76 Required	Attending NPI Qual	Inpatient and Outpatient: Enter the Last and First Name of the Attending Physician. Enter the National Provider Identifier Number of the attending physician who preformed the principal procedure.
77 Not Required Required if principal reason for admission is an operation	Operating NPI Qual	Inpatient and Outpatient: Enter the Last and First Name of the Operating Physician, if applicable. Enter the National Provider Identifier Number of the Operating Physician who preformed the any operation.
78 - 79 Not Required	Other	Inpatient and Outpatient: Enter the Last and First Name of other Physician if different than attending physician. Enter the National Provider Identifier Number of the physician who preformed the principal procedure if different than attending physician.
80 - 81 Not Required	Remarks CC	No entry required under HCRA

Appendix I

SAMPLE ITEMIZED PAID CLAIMS

(County Form Used to Provide Supporting Reimbursement Information to Hospitals)

HOSPITAL NAME: _____ DATE: _____

HOSPITAL # _____ COUNTY: _____

LAST, FIRST MI NAME	CASE NUMBER	ADMIT DATE	PAID # OF DAYS	AMOUNT PAID
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

NOTE: The Federal Poverty Guidelines will be issued in late February or early March each year

HEALTH CARE RESPONSIBILITY ACT (HCRA)

INCOME LIMITS

(100% of the Federal Poverty Level)

(Does Not Include Income Limits for Counties Eligible for the Spend-Down Provision)

If family unit's income is <= the amount shown on the chart for a household of the same size, then the applicant has met the income criterion for the HCRA program and may be eligible to participate.

If the family unit's income is > the amount shown on the chart for a household of the same size, then the applicant has not met the income criterion for the HCRA program and is not eligible to participate, unless he or she is a resident of a spend-down provision eligible county.

2016 Federal Poverty Guidelines 100% FPL Publication Date 1/25/2016 (Federal Register)		
Size of Family Unit	**Annual Income**	**Monthly Income**
1	$11,880	$990
2	$16,020	$1,335
3	$20,160	$1,680
4	$24,300	$2,025
5	$28,440	$2,370
6	$32,580	$2,715
7	$36,730	$3,061
8	$40,890	$3,408
For each additional family unit member add:	$4,160	$347

Updated 2/3/2016

SOURCE: U.S. Department of Health & Human Services (HHS), Office of The Assistant Secretary for Planning and Evaluation (Poverty Guidelines, Research, and Measurement - issued each year in the **Federal Register** by the HHS)
https://aspe.hhs.gov/poverty-guidelines

NOTE: The Federal Poverty Guidelines will be issued in late February or early March each year

HEALTH CARE RESPONSIBILITY ACT (HCRA)

SPEND-DOWN PROVISION
INCOME LIMITS

(150% of the Federal Poverty Level)

Income Limits for Counties Eligible for the Spend-Down Provision

If family unit's income is <= the amount shown on the chart for a household of the same size, then the applicant has met the Spend-Down Provision income criterion for the HCRA program and may be eligible to participate.

2016 Federal Poverty Guidelines 150% FPL Publication Date 1/25/2016 (Federal Register)		
Size of Family Unit	**Annual Income**	**Monthly Income**
1	$17,820	$1,485
2	$24,030	$2,003
3	$30,240	$2,520
4	$36,450	$3,038
5	$42,660	$3,555
6	$48,870	$4,073
7	$55,095	$4,591
8	$61,335	$5,111
For each additional family unit member add:	$6,240	$520

Updated 2/3/2016

SOURCE: U.S. Department of Health & Human Services (HHS), Office of The Assistant Secretary for Planning and Evaluation (Poverty Guidelines, Research, and Measurement - issued each year in the **Federal Register** by the HHS)
https://aspe.hhs.gov/poverty-guidelines