Preface

This Power Point is intended to be used **ONLY** as a **GUIDE** to assist counties with the processing of indigent cases. If you have questions please consult the Idaho Code and your county prosecuting attorney. Another alternative is to contact your neighboring indigent director.

The various Idaho Code section references are included.

Do Not Opinion Shop (use the information contained within the statute – your personal opinion may not be right)
Preface

This is also intended to try and standardize the process for all counties from the time services are received to the time a decision is made.

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Indigency Timelines

- Emergency Application (Maximum Times)
  - Person receives services; hospital submits combined application to IDHW/CAU: 31 days
  - Medicaid determination review: 45 days
  - County notification of denial: 1 day
  - County investigation process: 45 days
  - BOCC Decision – Approval: 15 days
  - Providers submit all medical bills: 60 days
  - County Payment (next billing cycle): 30 days
  - County Submits to CAT (after county pmt.): 14 days
  - CAT Board meetings (6-8 weeks): 56 days
  - CAT pays all approved cases: 45 days
  - Controller cuts checks to providers: 60 days
Indigency Timelines

- Non-Emergency Application (Maximum Times)
  - Person notifies county of services needed, county send for Medicaid determination 10 days
  - County Investigation Process runs concurrently with Medicaid 20 days
  - Medicaid determination review 45 days
  - County notification of denial 1 day
  - Providers submit all medical bills 60 days
  - County payment (next billing cycle) 30 days
  - County submits to CAT (after county pmt.) 14 days
  - CAT Board meeting (6-8 weeks) 56 days
  - CAT pays all approved cases 45 days
  - Controller cuts checks to providers 60 days
Declaration of Policy

- Each person is responsible for his or her own medical care
- Counties and Catastrophic program are the payers of last resort §31-3501
- However, individual counties may assist their county residents subject to the limitations of and requirements of Title 31, Chapter 35, Idaho Code.
HIPAA - The Health Insurance Portability and Accountability Act of 1996

- The Office of Civil Rights enforces the HIPAA Privacy Rules
  - Sets national standards for security of protected health information
  - Federal penalties for violations
- Policies and forms – provides for a paper trail
- Covered: ALL information
- Health care providers, plans, clearinghouses, & business associates
- Disclosure: Analyze who needs access & limit information sharing-minimum necessary
- Examine work space using safeguard assessment tools
HIPAA - The Health Insurance Portability and Accountability Act of 1996

- For all new staff and officials – must conduct HIPAA training.
- Check with county Clerk or HIPAA compliance officer, in your county, for training materials.
- Also, check with your Prosecuting Attorney as to whether the county indigent program is bound by all requirements of HIPAA.
Information Sources

- **Always check** Idaho Code and compiler notes for updates to the indigent statutes located in Chapters 34 and 35, Title 31, Idaho Code.

- **Internet:** [http://www.legislature.idaho.gov/](http://www.legislature.idaho.gov/) Click on Statutes and Rules
  - Review the annual updates to the Idaho Code located in various county offices or law library
  - **DO NOT** rely on old information or old laws
Information Sources

- **Always check** applicable Hospital interim rate.
  - Sent out by IAC 3-4 times per year;
  - Or on IAC’s website: [http://www.idcounties.org](http://www.idcounties.org)
    Click “Affiliates” then “Indigent”
  - Check to make sure you have printed all pages/tabs

- **Check County Pricing Manual**
  - Updates prepared by Bingham county
  - Check website: [http://www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov)
    To access pricing click medical on left side of screen; go to Medicaid, then Medicaid providers and finally Medicaid fee schedule;
  - Check with other county indigent directors
Hospital and Provider Screening Process

The purpose of these slides is to spell out the hospital/provider’s statutory requirements for determining whether an application should be filed for combined state and county assistance or not.

They also explain the necessary steps in the actual filing of a combined medical assistance application. Hospital/facility steps are different from provider/applicant steps in that different types of applications are results of the process.
Hospital and Provider Screening Process

- **Hospital screening begins** at the point of admission or scheduling of pre-authorization or request for additional services §31-3503E
  - Providers start the process
  - Upon stabilization, provider performs preliminary screening of applicant to determine indigency

- **Verify any available coverage, and obtain prior authorization.**
  - Providers are to check for other payment sources
Hospital and Provider Screening Process

- Consider eligibility for other resources §31-3502(25): Medicaid, Medicare, VA, Workers and Victims Compensation, SSI, Third Party or other insurance, CMS 1011

- Required prior authorization: means hospital/provider obtains prior authorization from insurance.

- Hospital shall consider patient’s ability to pay for billed charges of necessary medical services over a sixty (60) month period. §31-3502(25)

- Excludes interest charges

- Allows exemptions under 11-605 (1-3) and additional exemptions pursuant to county resolution.
Hospital and Provider Screening Process

- At some point, a decision must be made by the hospital regarding filing a combined application, based on:
  - Residency/obligated county
  - Medical indigency
  - Timelines for filing
  - Necessary medical services
  - Last resort

- Hospital shall complete combined application pursuant to 31-3502(2) and (7)
Hospital and Provider Screening Process

Application means combined application for county and state financial assistance.  
http://www.healthandwelfare.idaho.gov  Click on providers

- A Medicaid-only application is not a combined application
- Completed application includes the cover sheet requesting services, diagnosis and request for services, personal information of applicant, rights and responsibilities, and release and all other required signatures 31-3502(7)
- An incomplete application may be denied pursuant to 31-3505(6) and (7)

- Hospital shall transmit completed combined application to IDHW within 31 days of admission 31-3503E
Hospital and Provider Screening Process

- Provider screening begins at the determination of the need for non-emergency (10 day prior) necessary medical services.
  - Applicant and/or provider complete a combined application and submit to the county.
  - Hospital may also submit application to county and combined unit for processing.
  - County shall transmit combined application upon receipt or within 24 hours to IDHW for Medicaid eligibility determination 31-3504(1).
  - Necessary medical services are based upon a treatment plan.
Idaho Department of Health and Welfare Combined Application Unit

The following slides will outline the purpose and role that the IDHW/Combined application unit, has in the application process. Your county will only receive the application if it is denied by the Medicaid unit. The current process involves electronic filing through Security Connection Inc. and the process is outlined in the following slides.
Idaho Department of Health and Welfare Combined Application

- IDHW Business Process §31-3503E
  - Idaho Benefit Eligibility System (IBES)
- Approved Medicaid Eligibility – no application to county
- Denied Medicaid Eligibility
  - IDHW sends notice to hospital, county and patient
  - Notice includes reason for denial – categorically, incomplete, or financially ineligible
  - Incomplete applications
    - Attempts to complete
    - Eligibility for Medicaid has not been determined
  - 45 days processing
  - Up to 120 days processing for SSI determination
Idaho Department of Health and Welfare Combined Application

- Idaho Benefit Eligibility System – IBES
  - Provides for county use
    - Medicaid eligibility status
    - Eligibility begin and end dates
    - Search for clients/applicants
    - Verified income information
    - Verified expense information
    - Verified individual demographics
    - Household composition
    - Denial reason
Idaho Department of Health and Welfare Combined Application

- Access to IBES has been granted to counties for their investigation. While accessing, exercise caution in printing the screens as they may contain additional information that is protected.

- Application is faxed to the combined unit from the facility.
  - Check the fax date, usually on the top of the application pages, or application date on the Medicaid denial, to assure it is within the allotted time frame. (31 days from first date of service or 10 days prior on scheduled procedure or 180 day delayed)
Idaho Department of Health and Welfare Combined Application

- IDHW/CAU will make determination of Medicaid eligibility
- County receives notification of denied application via e-mail from IDHW, through SCI system (*shows up as- IT Notification*)
  - *(Retrieval of IDHW documentation for Combined Application)*
  - Print the SCI notification
    - Contains application date
    - DHW case number
  - Print application
Idaho Department of Health and Welfare Combined Application

- If not Medicaid eligible, IDHW/CAU will upload the application to the SCI server with the appointed counties’ H&W number. (ex: 8B-2012-10000) and e-mail the appropriate county of such upload.

- If you use SCI as your application database, create a PDF and submit the application and Medicaid denial through remote scan to your project.

- If you do not use SCI as a database, you will still need to upload the application to your system. SCI will be purging applications at approximately 90 days. If you leave your application on SCI, it will be lost after 3 months.
County Combined Application Process

- The combined application process was created to eliminate unnecessary county assistance applications and to allow the IDHW/CAU for determination of Medicaid eligibility first. The unit also has the ability to check on other resources and is included in the IBES Journal.

- The CAT program also contracted with Security Connections (SCI) to enable counties to electronically submit cases and enable IDHW/CAU to electronically notify counties of denials and upload the applications.

- The CAT office can provide SCI training for scanning for both CAT and CAU use.
County Combined Application Process

- County Business Process
  - 31 day emergency combined application
    - County notified via e-mail from SCI
    - Print SCI Notification
    - Contains application date and IDHW case number
  - 10 day prior combined application
    - Applicant/provider completes and files with county
    - Hospital may also submit application to county and combined unit for processing
    - Within 1 business day county transmits to IDHW-CAU for Medicaid Eligibility
    - Denied application transmitted to county as defined above.

- County time clock begins
  - Copy Combined Application (printed/digital)
  - Date stamp application
  - Review Application
County Combined Application Process

- Access IBES and review IDHW notes
- Move towards investigation and interview processes
Combined Application

The combined application for state and county medical assistance is required by Chapter 35, Title 31, Idaho Code and is defined in 31-3502(2) and a completed application is defined in 31-3502(7). *(See copy of Combined Application and Instructions)*

The following slides describe the combined application process in detail and what is required for a complete application.
County Investigation: Combined Application

- Cover Sheet (must be completed prior to submitting the application to IDHW/CAU):
  - Hospital/County Contact Information
    - Patient name
    - Dates of medical services provided
  - Hospital Contact Information
    - Name, address, phone, fax, e-mail and contact person
    - Signature of authorized representative, title and date
  - County Contact Information
    - Name, address, phone, fax, e-mail and contact person
County Investigation: Combined Application

- Page 1: Provider Information (Completed by Provider prior to submitting the application to IDHW/CAU):
  - Applicant’s signature
  - What preferred language spoken and written
  - Is interpreter needed
  - What medical services are being requested; providers discovered during the interview/investigation should be added per the patient’s request.
    - List provider names, addresses and phone
    - Dates of services (beginning and ending)
    - Types of service
    - Amount or cost of services
County Investigation: Combined Application

Page 2: Personal Information (Completed by Provider)

- Complete for Applicant and/or Spouse
  - Name, address, phone number and e-mail address
  - Date of Birth
  - Social Security Number
  - U.S Citizen or Sponsor name
  - Primary Doctor
  - Are you a Veteran
  - Registered to Vote (state/county)
  - Licensed to drive (state)
  - Native American tribal member
County Investigation: Combined Application

Page 3: (Completed by Applicant or County)

- Complete all information for people living with applicant
- Complete Residency section for the last 5 years of where the applicant actually lived
  - Start with the current address and word backward five (5) years
  - If more than four addresses in five years, additional pages may be included.
Page 4: Current Services and Health Coverage

- Check all programs where applicant is receiving assistance
- List all household members that are receiving assistance or have filed for forms of assistance listed
- It is imperative that the box be checked requesting IDHW health coverage for three months prior. Stress this to your providers and the applicant.
  - Make sure box is checked, because the CAU will not look at the prior month if the unit gets the application in the following month.
  - If the box is not checked, the applicant will need to make request in writing to IDHW/CAU for retroactive coverage.

- Does anyone in household have health insurance or had health insurance within the past 6 months

- Answer all questions listed
County Investigation: Combined Application

- Page 5: Legal Information
  - Complete all questions relating to convictions of a felony, probation/parole violations
  - Are there any pending lawsuits, accident claims or insurance settlements
  - Has anyone in household been disqualified from any assistance programs

- General Information
  - Does applicant have children, please list
  - Does anyone either pay or receive child support
  - Does anyone pay child/adult care expenses due to work or school
County Investigation: Combined Application

Page 6: Income and Resources

- List all current and previous employment information for applicant, spouse and other household members
  - Important for determining indigency and for reimbursement efforts
- Is anyone self-employed?
  - Business property, etc., is encumbered by the use of N-1
- Check all sources of income that apply and list details
Page 7: Assets

Please provide the following information on all assets listed: item, account number, owners name, bank name, value, amount owed

Examples include:

- All liquid assets: cash, checking, savings, CD’s, Mutual funds, stocks, bonds, Line of Credit, retirement, and credit cards
- Other real or personal property include: Home, land, vehicles, rental property, recreational vehicles, tools of trade, burial plots/funds, life insurance, other
- Has anyone in household sold, transferred or given away any cash, property or other assets within the past 5 years?
Page 8: Expenses

- Please provide the following information on all expenses listed: monthly amount, amount owed, names on account, and who received the payment

- Examples include:
  - Rent/mortgage; utilities (electric/heat/water/sewer/trash/phone)
  - Food/non food (if necessary ask for receipts or check the USDA food plan costs)
  - Insurance (auto/homeowners/life/health)
  - Transportation (vehicle payment/fuel/alternate transportation)
  - Medical (hospital/doctors/medications/dental/eyes)
  - Property/payroll taxes
  - Education expenses, child care, child support, garnishment, other expenses
County Investigation: Combined Application

- Page 9: Rights and Responsibilities (Completed by provider/patient prior to submitting the application to IDHW/CAU):
  - State Assistance
    - **Applicant** must read or have rights read to them and initial each statement (15 statements)
  - County Assistance
    - **Applicant** must read or have rights read to them and initial each statement (13 statements)
  - Page may be signed by *either* applicant or third party
County Investigation: Combined Application

- Page 10: Release of Information (Completed by provider/patient prior to submitting the application to IDHW/CAU):
  - Provide patients/applicants name, county, and co-applicant’s name
  - Must be signed by patient/applicant and/or co-applicant
  - Signature must be notarized
    - If not, notarize when applicant attends the interview
Page 11: Required Information

- An applicant must provide proof of all income, assets, resources, and expenses of all household members

- Identification:
  - Picture ID, Social Security cards, citizenship/residency documentation, and veterans status

- Income/Assets/Benefits:
  - Verification of all household income for past 6 months; (consider financial dynamics of the household. Why is the indigent applicant paying all the rent for 5 other working adults?)

- Expenses:
  - Provide all medical bills and proof of monthly expenses and outstanding debts utilizing the list shown
County Investigation: Combined Application

Example 1: (Timely Filed Application)

- The county receives an application with dates of service listed as October 1, 2011. The combined application unit received the application on October 29, 2011. It was received within 31 days beginning with the first date of service.

- Is this application timely filed? Yes, \textit{in this case the application would be considered timely.}
County Investigation: Combined Application

Example 2: (Untimely Filed Application)

- The county receives an application with the dates of service listed beginning October 1, 2011. The application was submitted to the combined unit November 5, 2011. This application would not be considered timely as it falls outside the 31 day emergency application filing date.

- Is this application timely filed? No. This application would not be considered timely as it falls outside the 31 day emergency application filing date.
County Investigation: Combined Application

County should:

- Review to determine if application is complete. A “completed application” includes at a minimum, the cover sheet requesting services, applicant information including diagnosis and requests for services signatures, personal information of the applicant, patient rights and responsibilities, releases and all other signatures required in the application. 31-3502(7)

- Demonstrate due diligence

- Send a letter requesting an interview

- Use public records information as part of investigation process

- Use the information release to verify residency, employment, assets, etc.
County Investigation: Combined Application

County should:

- ACT UPON all applications received; never refuse an application, even if you know they’re not your resident or they will not qualify. Doing so, may result in your county having to approve because your failed to act within the statutory timelines for investigation.

- Issue a subpoena if the applicant fails to respond
Recording of Liens

The following slides are intended to provide the

- How’s and why’s of the county automatic lien and state N-1 form;
- How to record/perfect the county lien and state N-1; and
- When to release county lien and terminate the state N-1.
Recording of Liens

- **County Automatic Lien Perfected: §31-3504(4)**
  - The county automatic lien, created by statute, attaches to all real and personal property including insurance benefits.
  - Must be recorded by the county within 30 days from receipt of a combined application
  - Priority date is the date the medical services were provided
  - *Sample county automatic lien*
Recording of Liens

- County Automatic Lien Perfected (continued)
  - Liens should only be released:
    - When the obligation has been satisfied
    - Debt is satisfied
    - If settlement offer is requested by applicant and approved by BOCC and CAT prior to release of lien (31-3510)
    - The board has denied the application and the 28 day appeal period has run
  - *Sample lien release*
  - A properly recorded lien survives bankruptcy only if it is attached to property before the bankruptcy is filed and counties cannot pursue reimbursement when the debt is discharged *(Mechling vs. Bonner County Assistance)*
  - Collection after bankruptcy is discharged:
    - No monthly payments may be billed
    - Sale of real property allows for counties to collect
      - *Talk to your prosecuting attorney*
Recording of Liens

- “Stop title” on a vehicle is to be filed with the Department of Transportation.
  - It is not a lien, a stop title is used to prevent the transfer of titled vehicles for a period of thirty (30) days to allow court proceedings to be commenced

- County N-1 Lien perfected on personal property:
  - Examples include business property and agricultural property
  - File the state N1 form with the Secretary of State (complete online or fax)
    - Forms can be downloaded at: www.idosos.state.id.us
    - Forms can be completed online by logging into the following: website:  http://www.sos.idaho.gov/UCCMed/login.aspx
    - Sample N-1 Form
Recording of Liens

- County N-1 Lien (continued):
  - To file electronically go to the following website [www.sos.idaho.gov/UCCMed/login.aspx](http://www.sos.idaho.gov/UCCMed/login.aspx) *(See User Guide)*
    - If not already done, you will be asked to set up your account.
    - Once logged in, you are in the “Data Entry” tab
      - Enter person’s last name, first, middle initial, address, city, zip code
    - Tab down to:
      - Medical services date; application date; electronic signature
  - Hit the “Save for Filing” button
  - Go to File and Print (review the information) and if correct then click on “Save” to file the lien
  - The system enters the lien with the lien number below the information (click on lien number to print the lien)
  - To terminate an N-1 form, go to terminate tab and enter the lien number to terminate and follow the prompts.
Types of Applications

The following slides are designed to provide an overview of the time frames required for receipt and processing of applications by either the applicant or third party applicant.

- Emergency Application
- Non-Emergency Application
  - Follow-Up for Necessary Medical Services
  - Request for Additional Treatment
- 180 Day Delayed Application

Please remember that the indigent program is incident based and is not an entitlement or medical card.
Types of Applications: Third Party Application:

- “Applicant” means any person who is requesting financial assistance under this Chapter 35, Title 31.
- “Third party applicant” means a person other than an obligated person who completes, signs and files an application on behalf of a patient
  - Third party must submit completed application, which means the patient must sign and initial in appropriate areas and must sign release
  - Same responsibilities as any other applicant
  - County sends missing documentation list to 3rd party
- Hospital sends copy of application to patient within 3 days of filing on their behalf 31-3502(26)
Types of Applications

Counties receive different types of applications, each with their own specific requirements and timelines any of which may be filed as a third party application. 31-3505(26)

- Emergency Application 31-3505(2)
- Non-Emergency Application 31-3505(1)
  - Follow-Up for Necessary Medical Services §31-3504(3)
  - Requests for Additional Treatment 31-3505(4)
- 180 Day Delayed Application 31-3505(5)
Emergency Applications

- “Completed Application” defined 31-3502(7)
  - “Completed application” shall include at a minimum the cover sheet requesting services, applicant information including diagnosis and requests for services and signatures, personal information of the applicant, patient rights and responsibilities, releases and all other signatures required in the application.
Emergency Applications

- Emergency Defined:
  - Emergency medical services: Services provided for a medical condition which is sudden, serious and unexpected symptoms of illness or injury calls for immediate care. §31-3502(12)

- Emergency Application Timeframes:
  - All combined applications for necessary medical services shall be transmitted to the combined application unit for a Medicaid determination within the time frame listed below.
    - For hospitalization, 31 days beginning with the date of admission. §31-3505(3)
Emergency Applications

Example 1:

- George, a 33 year old single unemployed male, is experiencing abdominal pain and accesses the local emergency room. He has lived in Alturas County Idaho his entire life. The diagnosis is appendicitis and immediate surgery is preformed. The application was filed within 31 days of the date of service.

- Is this a timely filed application? Yes
Example 2:

- Reginald, a 22 year old single unemployed male, fell on the ice while walking his dog in the park and broke his leg December 12, 2011. He went to the emergency room December 14, 2011. The application was received by IDHW/CAU January 12, 2012. The denial notification and application for emergency services was received by his resident county on January 17, 2012.

- Is this a timely filed application? Yes
Example 3:

- Reginald, a 22 year old single unemployed male, fell on the ice while walking his dog in the park and broke his leg December 12, 2011. He went to the emergency room December 14, 2011. The combined application was received by IDHW/CAU January 22, 2012. The denial notification and application for emergency services was received by his resident county on January 30, 2012.

- Is this application timely filed?  No, because the application filed with IDHW/CAU was after the 31 day emergency timelines.
Emergency Applications

Example 4:

- Hospital contacts the county regarding an application they claim was filed. County has no record of receiving the application. Hospital informs county that the application was submitted to IDHW/CAU timely. SCI does not have any record of the filing.

- What should be done? *Have the hospital submit proof of filing date of the application and resubmit the application to IDHW/CAU. IDHW/CAU will make determination and submit through the SCI portal. County received application through SCI for processing.* Consult with your Prosecuting Attorney.
Emergency Applications

- Requests for other providers and dates of service not listed on original application – must be submitted within 31 days of the provision of medically necessary emergency services and approved by the patient
  - In the case where additional providers and dates of service are determined after the application has been filed:
    - The provider/patient may file a completed application per I.C. 31-3505(7) under the listed statutory time frames.
      - 31 day emergency filing
      - 10 day prior – non-emergency care
      - 180 day delayed
  - Or, the patient may request to amend the original application and add the additional dates of service and/or providers as long as they are filed in accordance with Chapter 35 Title 31 under the listed time frames.
Emergency Applications

- The patient must acknowledge the amendment by initialing and dating the changes as long as the patient has previously signed the original application.

- Application is still pending at IDHW/CAU, the applicant or provider may submit an addendum listing the additional providers and dates of service
  - Provider may submit a completed application with the diagnosis, and requested providers and dates of service along with the applicants signatures on the combine application if still being reviewed by the Combined Application Unit at DHW
  - Provider may submit the above information and any other updated information to the county if no decision has been made by the BOCC.
  - If application is already approved or denied, the additional providers and dates of service would have to be communicated as a new application.
Emergency Applications

Example 1:

Facility files application for Sara Jean with the Combined Unit on January 22, 2012 for date of service 12/31/11. Sara Jean returns to hospital emergency room and is admitted again on 1/25/12. Combined unit has not made a decision on the application. How is the additional date of service handled?

ANSWER: Provider/patient submits a completed application to IDHW/CAU within 31 days from the date of necessary medical services. Once IDHW/CAU makes a Medicaid determination IDHW/CAU will forward the application(s) to the county for processing.
Emergency Applications

Example 2:

- Facility files an application for Sara Jean with the Combined Unit on January 22, 2012 for a date of service 12/31/11. Sara Jean returns to the hospital emergency room and is admitted again on 1/25/12. The Combined Unit has denied Medicaid and forwarded the original application on to the obligated county. How is the additional date of service handled?

- Answer: *A completed application will need to be filed within 31 days of the receipt of the services and sent to the OBLIGATED COUNTY. The county will consider the add-on along with the application.*
Example 3:

- Facility files an application for Sara Jean with the Combined Unit on January 22, 2012 for a date of service 12/31/11. Sara Jean returns to the hospital emergency room and is admitted again on 1/25/12. The Combined Unit has denied Medicaid and forwarded the original application on to the obligated county. The BOCC also denied the application. How is the additional date of service handled?

- ANSWER- Requires that a new complete application be submitted through the Combined Unit.
Non-Emergency Application

- Applicant/provider will complete and submit a combined application to county.
  - Combined Applications must be submitted 10 days prior to receiving services §31-3505(1)
  - County transmits 10 Day prior combined application to IDHW/CAU for Medicaid eligibility determination.
  - Hospital may also submit application to county and combined unit for processing.
  - County receives returned copy of original 10 Day Prior application and Medicaid denial back from IDHW/CAU after completion of Medicaid eligibility determination. §31-3503E
Non Emergency Applications

- County has 20 days from receipt of original application to complete investigation process. §31-3505A(3)
- Requested services provided to an applicant from the 11th to the 20th day may be considered eligible for county financial assistance if the person is otherwise eligible.
  - Treatment/services provided after the 10th day may still be considered for payment if the applicant is otherwise eligible.
  - Providers and applicant run the risk of denial by county, if they proceed before approval.
Non Emergency Applications

Example 1:

- Barbara, a 38 year old single unemployed female, seeks services through the emergency room for back pain and is referred to a surgeon. The surgeon determines that services are medically necessary and schedules the surgery for 2 weeks later.

- When should she file the application? Since the services are scheduled, a 10-day prior application can be filed immediately. No need to wait until only 10-days out.
Non Emergency Applications

Example 2:

- Kathy, a 48 year old single unemployed female, with back pain sees a surgeon November 1, 2011. The surgeon schedules the surgery for Monday November 14, 2011. The provider faxes an application for pre-authorization of services on Friday November 11, 2011.

- Is the application timely filed? No, because the application was not filed 10 days prior to the receipt of non emergency services.
Non Emergency Applications

Example 3: (with services already provided)

- Melvin, a 52 year old single unemployed male, has been diagnosed with cancer. The doctors prescribed 6 weeks of chemotherapy. His first treatment is scheduled for January 9, 2012. The combined application is faxed to the county on January 20, 2012.

- How would you process this application? *The chemotherapy may be denied for being an untimely filed application up to January 29. Consider it being timely filed for January 30 through March 12 if he is otherwise eligible.*
Non Emergency Applications

“Completed Application” defined 31-3502(7)

“Completed application” shall include at a minimum the cover sheet requesting services, applicant information including diagnosis and requests for services and signatures, personal information of the applicant, patient rights and responsibilities, releases and all other signatures required in the application.
Non Emergency Applications

- Follow-up Necessary Medical Services §31-3504(3)
  - Work with the applicant and note any planned follow-up treatment on the initial application during interview process.
  - Must be for the same condition
  - Must be based on a treatment plan
    - Pre-approved by the BOCC
    - See Treatment Plan Slide (Slide 139)
  - Services may be provided for a maximum of six (6) months
Non Emergency Applications

- Requests for Follow-Up Services Related to the Original Application §31-3505(4)
  - If need for follow-up treatment is determined after the application is filed, requested services must be communicated as a completed application and:
    - Related to the original diagnosis
    - In accordance with a preapproved treatment plan
    - Filed 10 days prior to receiving treatment
  - If the follow-up services are beyond 6 months from the original application for the same condition:
    - Contact the county of residence
    - Requests for additional treatment must be filed 10 days before receiving services
    - CAT Program requires submission of a new complete application.
Non Emergency Applications

- Requests for Additional Treatment (continued)
  - If unable to delay treatment for 10 days, then file it as an emergency application.
  - Application is still pending, the applicant or provider may:
    - submit a completed application to IDHW/CAU with the diagnosis and request for services and signatures of the combined application to the IDHW/CAU if it still being reviewed by the IDHW/CAU; or
    - submit the above information and any other updated information to the county if no decision has been made by the Board of County Commissioners.
  - If application is already approved or denied by the BOCC, the need for additional treatment would need to be filed as a new 10 day prior application.
Non Emergency Applications

Example 1:

- Jimmy, a 29 year old unemployed single male, fell off his porch at home. He broke his leg and had a pin placed during surgery. Four months later the pin needs to be removed.

- When should he apply for the pin removal? *The applicant should file a completed application for this additional request with the county 10 days prior to receiving services, if the BOCC has not already approved this service per the treatment plan.*
Non Emergency Applications

Example 2:

- Wanda, a 52 year old divorced unemployed female, received services for a scheduled pancreatic cancer surgery. Prior to the surgery, Wanda was diagnosed with gout and the surgery was postponed. The hospital calls and wants to include the gout as an “additional treatment.”

- Should this be added as a Request for Additional Treatment?

It was not related to the original diagnosis and would require a new application. Requests for additional treatment always require a 10 day prior application or in the case of an emergency, a 31 day emergency application may be filed depending on the diagnosis.
Non Emergency Applications

Example 3:

- Danny, a 36 year old single unemployed male, had previously filed an application with the county for repair of a torn meniscus in his knee and was approved. At the time of the initial application it was determined that physical therapy was not needed. During the surgery more damage was noted and physical therapy was warranted beginning 2 weeks after surgery.

- When and how should the applicant apply? The applicant should file a completed application for the additional treatment with the county 10 days prior to receiving services for the physical therapy.
180 Day Delayed

- Patient or provider files *Bona Fide* application or claim with one of the following §31-3505(5)(a)(i-v): Social Security, Supplemental Security income, third party insurance, Medicaid, Medicare, crime victims’ compensation, and/or worker’s compensation.

  - Proof of filing should be attached to the application or within 45 days of filing the delayed application.
    - File with county within 180 days of the first date of the initial services.
    - Must have a reasonable expectation of eligibility and resource will cover the requested dates of service.

- Applicant must complete application process with the above resources including appeals or it will result in a denial of county assistance. 31-3505(5)(b), 31-3505(6)
180 Day Delayed

Example:

- James, a 33 year old employed male, who has an insurance card in his wallet, has a heart attack on March 23, 2011. The facility checks with the insurance on April 10, 2011 and is told James has insurance. On May 15, 2011 the hospital bills the insurance company. On June 1, 2011, the insurance company denies the claim based upon the individual has reached the yearly allowed maximum. The facility files a county application on June 20, 2011.

- Can the (county) applicant or hospital file a 180 day delayed application? *A Bona Fide application to insurance was filed and actively pursued by the facility. County should process as 180 day delayed application.*
The purpose of these slides is to explain the procedures used to properly investigate a combined application for state and county medical assistance.
County Investigation Overview

- On going process
  - Begins upon receipt of application; use signed release as part of the investigation
  - Occurs before, during and after the interview

- Develop a checklist
  - Agencies to check – power company, area service agencies, etc.
  - IBES – Check the IDHW Journal in the IBES portal
  - Dates of service
    - Check beginning and ending dates of service
  - Comments taken during interview
    - Used for investigation purposes

- Compare documentation
  - Dates and addresses of all information
County Investigation Overview

- Receive application from Combined Unit/IDHW and date stamp the day you receive the application.
- Check to make sure application is timely filed $§31-3504$
- Send notice of interview to applicant
  - Schedule date and time of interview
  - Provide documentation list to applicant
  - See sample documentation list
- Review application for completeness
  - List any missing information
  - Required information pursuant to $§31-3502(7)$ Suggestions-
    try this first:
    - If minimal information is missing from the required pages then contact the person who filed the application
- Request medical records and any treatment plans
- Begin interview and investigation process
The purpose of these slides is to explain the procedures to determine if the applicant is a resident of the state of Idaho. Residency test consists of two prongs, residency and obligated county. The first test is to determine if the application has met the 30 consecutive days of residency in the state of Idaho.
County Investigation: Residency

- The first test is to determine whether the applicant has resided in Idaho for 30 consecutive days or more §31-3502(24)

- Has the applicant resided in a county for 30 consecutive days or more prior to the receipt of necessary medical services
  - Review the following factors:
    - Landlord forms, rental receipts, leases, bank statements, utility bills, drivers license, voter registration list, auto title and registration and other documentation
    - Not considered a resident if the applicant has not resided in Idaho for 30 consecutive days or here for temporary purposes
      - Temporary purposes includes but are not limited to: education, vacation or seasonal labor
County Investigation: Residency

- **Homeless**
  - Notarized statements
  - Verification from IDHW – Idaho mental health
  - Hotel/Motel – verification
- Where do they receive their mail?
  - Send Interview notification to General Delivery
- **Affidavit of Residency (See sample affidavit)**
  - What is your permanent address
  - If you file income tax, what state?
Example 1:

- Harold, a 39 year old single unemployed male, lived in Wilbur, Washington for 19 years. Harold had an emergency appendectomy and an application was filed with Bonanza county. He moved to an apartment in Bonanza county, Idaho and lived there for 30 consecutive days with a job pending and the intent to permanently reside.

- Is he a resident of Idaho? Yes, he would be considered an Idaho resident because he resided in the state and same county for 30 consecutive days and intended to remain.
County Investigation: Residency

Example 2:

- Roger, a 58 year old single unemployed male, lists his address as general delivery on the application and states he lives under the bridge. He went to the ER with chest pains and was diagnosed with pneumonia. He stated that he lived in Husky county Idaho for 60 days.

- Is he a resident? To make that determination:
  - Check with Idaho Mental Health to see if the person has accessed services;
  - Check IBES for food stamps;
  - Check with the local ER rooms and see if an address was given;
  - Check with the Idaho Repository for contact with law enforcement;
  - Send the applicant an Affidavit of residency to complete.

- These are difficult situations to access. *(See Slide 86).*
County Investigation: Residency

Example 3:

- Lee, a 62 year old unemployed single male, lived in Wilbur Washington for 19 years and moved to Husky County, Idaho for 30 days. He then moved to Clarkston, Washington for 90 days and returned to HUSKY County where he had lived for the last 20 days. The county received a 31 day emergency application for an appendectomy.

- Is he a resident of the state of Idaho? No, he would not be considered an Idaho resident as he did not have 30 consecutive days residing in the state prior to the date of admission.
County Investigation: Residency

Example 4: (using an institution)

- Seth, a 29 year old single unemployed male, was living in Milford, Washington for 15 years was picked up on a protective hold and placed at State Hospital North for 90 days. He is placed at a motel in Vandal county and seeks hospitalization for a suicide attempt after 10 days at the motel.

- Is he an Idaho resident? *No, he would not be considered a resident as you cannot gain residency while in an institution.* §31-3506
County Investigation: Residency

Example 5:

Herb, a 38 year old unemployed, divorced male, was released from Idaho State Penitentiary on August 15, 2011 to live in his sister’s home in Alturas county. He had been incarcerated for 15 years for murder. He had chest pains October 12, 2011 and was admitted to the hospital where he incurred a $58,443.26 bill. Herb was sentenced to his prison term in the Snake River county court July 8, 1996 and had been in the Snake River county jail from January 6, 1996. Prior to his arrest, he lived in Snake River county with his ex-wife since their divorce November 5, 1995. Before his divorce, his wife had kicked him out and he lived with his parents in Freeloader county from January 1, 1995. He had lived with his wife in his childhood home in Snake River county and told the hospital representatives he had been born and raised in Juniper.

Which county is obligated? Use a timeline on Slide 92
County Investigation: Residency

Example 5 (continued):

- **Timeline:**
  - Alturus County – August 15-October 12, 2011 (2 months)
  - Penitentiary – July 8, 1996-August 15-2011 (14 years 11 months)
  - Snake River County jail – January 6, 1996 – July 7, 1996 (6 months)
  - Snake River County – November 5, 1995-January 6, 1996 (2 months)
  - Freelance County – January 1, 1995-November 4, 1995(10 months)
  - Juniper County – 1973 through December 31, 1994

- **Answer:** *The time in the county jail adds on to the “county where he lived just prior to going to jail” which gives him 8 months in Snake River county and satisfies the 6 months obligated county provision. Serving time in the penitentiary does not change the obligated county.*
County Investigation: Residency

Example 6:

- Jasper is a 35 year old single male. He was living in Oscar County Idaho for 15 days then moved to Wilder County Idaho for 25 days. He works at the local Dairy Queen and they are holding his job. He became ill and was placed in the psychiatric unit in Oscar County for 3 days then went to State Hospital South for 90 days.

- Is he an Idaho Resident? Yes, Jasper has been in the State of Idaho for more then 30 days and intends to return to work.
OBLIGATED COUNTY

The purpose of these slides is to explain the second test of “residency” and will establish which county in the state of Idaho will be potentially liable for payment of necessary medical services for a medically indigent applicant.

Once state residency requirements (first test) have been met, these slides take the process one step further and explain how to determine which county will be obligated.
County Investigation: Obligated County

- **The second test** is to determine which county is responsible for payment of necessary medical services. §31-3506

- **Responsible county for payment**
  - For medical care, last county where applicant maintained residency for six consecutive months or longer within the last five years
  - Less than six months
    - 30 consecutive days preceding incurrence of medical expenses
      - If individual has not resided in any county for 30 consecutive days, but has been in the state of Idaho, the obligated county would be where the patient resided prior to hospitalization
County Investigation Obligated County

- Less than 6 months residency (continued)
  - 30 consecutive days in Idaho - §31-3506(E)

- Pharmaceuticals for non-institutionalized residents where the applicant currently resides.

- If a different county is determined to be the obligated county: §31-3505(8)
  - Notify applicant and third party applicant of denial
  - Notify the county that is believed to be obligated and provide basis for determination (denial)
  - Applicant or third party applicant may submit an application to indicated county

- Institutionalization shall not change obligated county §31-3502(24) and 31-3506(c)
  - The obligated county shall be the obligated county prior to institutionalization
County Investigation: Obligated County

- For full time college students the obligated county shall be the residence of the applicant.
- Unless – applicant is claimed as a dependent and parents reside in another state or county
  - The applicant will remain a resident of the parents’ state or county
County Investigation: Obligated County

Example 1:

- Katie, a 48 year old single unemployed female, has lived in Burley, Oregon for 25 years. She moves to Bronco county, Idaho where she lived for 5 ½ months. She moves to Vandal county, Idaho and lives there for 1 month and then goes into the hospital.

- Who would be the obligated county?
  - First test: Did the applicant live in Idaho for 30 consecutive days or longer? Yes
  - Second test: Did the applicant live in any county in Idaho for 6 consecutive months or longer in the last 5 years? No

- Look to §31-3506 (b). The applicant maintained a residence for 30 consecutive days prior to hospitalization in Vandal county and is considered the obligated county.
County Investigation: Obligated County

Example 2:

- Thomas, a 41 year old single unemployed male, has lived in Milford, Washington for 19 years. He moves to Capital county where he lived for 5 ½ months. He then moved to Vandal county and lived there for 16 days before going into the hospital.

- Who would be the obligated county?
  - First test: Did the applicant live in Idaho for 30 consecutive days or longer? Yes
  - Second test: Did the applicant live in any county in Idaho for 6 consecutive months or longer in the last 5 years? No

- Look to §31-3506 (b) – The applicant maintained a resident for 30 consecutive days prior to hospitalization in Capital county and is considered the obligated county.
County Investigation: Obligated County

EXAMPLE 3:

- Matt is a 26 year old single male attending Outback College in Shrimp, Idaho for the last 6 years. Matt fell out of bed and broke his arm at his apartment and required surgery. He stated that he had insurance through his family who lives in Barbie, Utah, the college insurance was waived. His family did not provide insurance coverage after his 26th birthday and a county application was filed.

- Who would be the obligated county? Shrimp County as he has lived in Idaho for the last 6 years and is not claimed on his parents income taxes.
EXAMPLE 4:

- Paris, a 27 year old female, lived in Houdini, Utah for 26 years. She moved to Wichita County where she lived for 8 months. She then moved to Macon County where she resided 31 days prior to her hospital stay.

- Who would be the obligated county?
  - First test: Did the applicant live in Idaho for 30 consecutive days or longer? Yes
  - Second test: Did the applicant live in any county in Idaho for 6 consecutive months or longer in the last 5 years? Yes (Wichita County is obligated)
County Investigation Overview: Subpoena Process

- Clerk is authorized to issue subpoenas
  - Compels compliance – check codes
  - Issued in accordance with Idaho law
    - 31-3505A(1) The clerk is authorized to issue subpoenas
    - 31-845 Enforcement of attendance and testimony
      - Witness is bound to attend when served, and to answer all questions
    - 9-709 Disobedience of subpoena
      - A witness who disregards a subpoena may be assessed a fine of $100, and all damages for failure to attend – may be recovered in a civil action
  - Service may be personal or by certified mail
Interview Process

This section is designed to provide you information about the interview process. How to conduct an interview, type of interviews, investigation processes and the types of documentation that you will need to assist in making a determination.
County Investigation: Interview

- Communicate with the Applicant
  - Send notice of interview
    - Include date, time, place and phone number
  - Conduct phone interview
    - Only if no alternative exists (providing documentation is still required)
  - Reschedule interview if necessary
  - Provide list of missing documentation with expected date of return
    - If a provider has requested, you must make the provider aware of the missing information §31-3505A(1)
County Investigation: Interview

- Interview shall take place §31-3505A
- Develop paper trail
  - Treat every application as if you will have to testify and show your diligence in a hearing
- Ask open ended questions, the more they talk, the more they reveal
- It is a time of discovery
  - Assets
  - Income
  - Available resources
  - Last resort
County Investigation: Interview

- Documentation/verification in writing for the following:
  - Rent verification *(See Sample Form)*
  - Employment/Wage verification *(See Sample Form and Department of Labor Form)*
  - Bank statements *(See Sample Bank Request Form)*
  - Current monthly expenses
  - Titles and Registrations
  - Tax returns
  - All insurance policies (Auto, Life, etc.)
County Investigation: Interview

- Documentation
  - Verify: Income, assets, residency, expenses, and debts.
  - Accepted proof: Income, assets, residence, expenses, and debts, cancelled checks, money orders, payment receipts, and bank statements
  - Check listed addresses and dates on all documents
  - Make a timeline, if necessary to determine residency
    - Vocational Rehabilitation
    - Food stamps
    - Federally Qualified Health Centers (FQHC’s)
County Investigation: Interview

- Note any planned follow-up treatment during interview process (note additional providers on page 1 of the combined application)
  - Discuss applicants responsibilities & expectations
    - Cooperation
    - Reimbursement
    - Missing documentation
      (See Sample Patient Acknowledgment form)
  - Fill in the blanks
    - Verify dates of service; make sure there is a stopping date on page 1 of the combined application
  - Give choices with limits
County Investigation: Interview Techniques

- Be the County Ambassador
  - Be prepared
  - Gain client trust
  - Be courteous
  - Avoid interruptions
  - Ask the right question the right way
  - Don’t stress the applicant, make them feel more comfortable
  - Listen attentively
County Investigation: Interview Techniques

- Be the County Ambassador (continued)
  - Review file
    - Send for additional information
    - Check all leads
  - Completely prepare your files
    - REVIEW IDAHO CODE AND COMPILER NOTES
    - Review indigent court cases
    - Make timelines of events
    - CHECK WITH PROSECUTING ATTORNEY
The purpose of these slides is to provide a general explanation of alternate resources which should be considered during the investigation as they may be alternative sources of payment to county medical assistance.

Your county should check any and all other potential resources including but not limited to auto insurance, stocks, bonds, life insurance, etc.
County Investigation: Resources

- Definition of Resources §31-3502(25)
- Consider all resources in the investigation process whether eligible, have an interest or pending
  - 60 month repayment
    - The applicant has sufficient income and/or assets to pay for their own medical expenses.
  - Tangible - capable of being valued monetarily
    - Land or securities
  - Intangible - represents value
    - Stock certificates, promissory notes or copyrights, etc.
  - Real or personal property
  - Liquid - readily converted to cash
    - Cash on hand, certificates of deposit, checking & savings, etc.
County Investigation: Resources

- Consider all resources in the investigation process for which the applicant would be eligible for, have an interest in or have pending
  - Non-liquid - takes time to get available funds
    - Real estate, most investments
  - Forms of public assistance
    - Medicare
    - Medicaid
    - Supplemental Security Income
    - Crime Victims Compensation
    - Workers Compensation
    - Third Party Insurance
    - Veterans Administration Benefits
    - CMS 1011 Program
County Investigation: Resources

  - Different parts of Medicare help cover specific services
  - Age - 65 and older/worked 10 years in Medicare covered employment
    - Only qualified for social security retirement
  - Receiving retirement benefits from Social Security or Railroad Retirement
  - Disability - 2 year waiting period
    - Qualified under Social Security Disability
County Investigation: Resources

- Medicare Part A (Hospital Insurance)
  - Helps cover inpatient care in hospitals
  - Helps cover skilled nursing facility, hospice and home health care

- Medicare Part B (Medical Insurance)
  - Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care
  - Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

- Medicare Part C (Also known as Medicare Advantage)
  - Offers health plan options run by Medicare-approved private insurance companies
County Investigation: Resources

- Medicare Part C (continued)
  - Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
  - Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
  - Some Medicare Advantage Plans may include extra benefits for an extra cost

- Medicare Part D (Medicare Prescription Drug Coverage)
  - Offers health plan options run by Medicare-approved private insurance companies
  - Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
  - Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
  - Some Medicare Advantage Plans may include extra benefits for an extra cost
County Investigation: Resources

- Medicare, Part A, Part B, and Part D

- ESRD - End Stage Renal disease (contact Voc. Rehab office until July 1, 2012 as program is being phased out)
  - Had provided support services such as transportation, prescriptions, and insurance premiums
  - Potential assistance programs for this may include: Medigap, Indian Health Services, Veterans Affairs benefits, SSD/SSI, American Kidney fund, National Kidney Foundation

- Make referrals to IDHW for Specified Low Income Medicare Beneficiary (SLMB) and Qualified Medicare Beneficiary (QM)

- See Additional Assistance Programs
County Investigation: Resources

- Medicaid
  - Medical coverage
  - Certain individuals with dependent children
  - Children of low income families
  - Aged, Blind or Disabled
    - Disabled according to Social Security definition of disability
      - 1 year or longer being disabled or disability results in death
      - Non-employed disabled individuals according to IDHW income limits: $707/month, couples limit $1011
      - Working nondisabled individuals without children in the home will not qualify
  - Idaho residents
  - U.S. citizens or legal non-citizens
County Investigation: Resources

- Medicaid
  - If an applicant is eligible for Medicaid, counties will not receive a combined application.
  - However, if an applicant fails to comply with Medicaid, the county will receive the combined application along with the Medicaid denial
    - The county may deny the application if the applicant fails to follow through with Medicaid requests.
    - Make sure to read the denial
County Investigation: Resources

- Social Security and SSI/SSD
  - Social Security
    - Is the income portion of disability
    - Does not pay for medical care
    - Does process applications that may enable a person to qualify for Medicare or Medicaid
    - *(See Sample SS Inquiry Forms)*
County Investigation: Resources

- Social Security and SSI/SSD (continued)

  - SSI – Supplemental Security Income
    - 65 and older
    - Totally blind
    - Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or result in death
    - Your income level has been minimal (inability to maintain gainful employment over long period of time)
County Investigation: Resources

Social Security and SSI/SSD (continued)

- If the applicant is pending SSI or is at the DDU unit, the Combined Unit may hold onto the application for 120 days before uploading to the county.
  - These circumstances may lead to the county entering a “Suspension” and tolling the application until the determinations are final. *(Please see criteria for Suspension Slide 182-183)*

SSD – Supplemental Security Disability

- Any age
- Must be adjudicated disabled
- 24 month waiting period before Medicare eligible
County Investigation: Resources

Example: (SSI application not listed, but is discovered during the investigation)

- Tammy is a single 62 year old unemployed female. She was treated for gallbladder disease and later diagnosed with terminal cancer. Tammy had not filed for SSI at the time the application was submitted to the IDHW/CAU. Tammy called Social Security to secure her filing date at the time of interview with the county.

- How should this application be processed? If indigent, the application can be put into suspension as Tammy was unemployed at the time services were rendered and her illness is terminal.
County Investigation: Resources

- **Crime Victims Compensation Program** *(Chapter 10, Title 72, Idaho Code)*
  - Crime occurred in Idaho, resulting in injury
  - Report to police within 72 hours and cooperate with the investigation
  - Injured party did not cause or contribute
  - Payments to providers 72-1026
    - The commission may adopt a fee schedule
      - Determines allowable payment to providers
      - Payment from commission is payment in full
      - *Review this section with your Prosecuting Attorney*
  - [www.iic.idaho.gov](http://www.iic.idaho.gov)  Idaho Industrial Commission
County Investigation: Resources

- Example:
  - Feivel, a 39 year old heavy equipment operator, was involved in an altercation at Festus’ Bar in Old West County on January 1, 2012. Feivel was hit on the head with a bottle of Jack Daniels and spent 10 days in the hospital. The police were called and a report was made that night. An application into Crime Victim’s compensation program was initiated. However, there was some discrepancy in the subject’s reports as to what happened even though Dillon Marshall was charged with aggravated assault. The facility made application into Old West County just to be safe as Feivel lost his job due to the time he was off work.

- County may deny pending alternative resource under the suspension process.

- Can the application be suspended? Yes. Because Crime Victims’ qualifies as a resource under suspensions.
County Investigation: Resources

- **Workers Compensation**
  - Work related injuries or occupational illness
  - Must notify employer within 60 days of incident
  - Up to one year to file claim
  - Self-employed individuals are not eligible
  - Patients can file even if employer refuses
  - Always ask patient to file with the Industrial Commission if coverage status is unknown
  - Check Compiler Notes St. AL’s vs. Canyon - 1991
Example:

- Jack is a 22 year old male working for an antique store and gets paid under the table. Jack was moving furniture and injured his back which will require surgery. During the interview Jack reported what happened to the Clerk. He did not file a workers compensation claim because he feared he would lose his job. Discussed the need to be the payer of last resort and reimbursement. Jack filed a workers comp claim the next day and reported it to the county.

- Jack still wants to file a county assistance application. Is the county the last resort? No, Jack filed a worker compensation claim – suspend the application.
County Investigation: Resources

- Third Party Insurance
  - Any insurance source that may pay on behalf of the patient (first party) to the provider (second party)
    - Individual insurance policies (Auto)
    - Employer-sponsored health plans
    - Liability or premises medical insurance
  - This question will come up (Is PCIP considered a third party insurance available, if the applicant has the ability to pay the premium and deductible)
County Investigation: Resources

Example 1: (Insurance paid on a hospital bill before the county received an application for assistance)

- Joe slips and falls down Sara’s icy steps. Joe incurs $60,000 in medical expenses. Sara has a homeowner’s policy that has liability for accidents that occur on her property. The policy maxes out at $45,000 med pay. The Medicaid rate at the facility was 55%.

- Total Hospital Bill $60,000
- Medicaid Rate on total bill (55%) $33,000
- Subtract Insurance payments -$45,000
- County liability 0

- Is the person indigent and is the county responsible? No
Example 2:

- Bill slips and falls down Jane’s icy steps. Bill incurs $50,000 in medical expenses. Jane has a homeowner’s policy that has liability for accidents that occur on her property. The policy maxes out at $10,000 med pay. The Medicaid rate at the facility is 50%. The provider has received $10,000 from the liability insurance.

- Does Bill meet medical indigent criteria. If yes, what does the county owe?
  - Total hospital bill: $50,000
  - Medicaid rate on total bill (50%): $25,000
  - Subtract insurance payments: $10,000
  - County liability: $15,000

- Is the person indigent and is the county responsible? Yes, and the amount is $15,000 after all calculations.
County Investigation: Resources

- VA Millennium Fund
  - Eligibility
    - Patient must be enrolled in VA health care
    - Seen by VA provider within last 24 months
    - Have no other form of insurance
    - Treatment for emergency condition
  - Notice: Report admission within 72 hours
    - Upon stabilization, the facility and VA work together to transport qualified Veterans to a veterans facility
  - Payment
    - Is at 70% of the Medicare rate
    - Is payment in full - Cannot bill patient for balance
VA Millennium Fund (continued)

Payment (continued)

- Claims paid by the county prior to a VA decision are not reimbursable from the VA unless the veteran had prior approval for the procedure

The DD-214 (Certificate of Discharge or Release from Active Duty), or its equivalent, is the basic document used to establish eligibility for any VA benefits

Contact Points:

- Online at [www.va.gov](http://www.va.gov) for benefit information
- Veterans Administration Medical Center, as appropriate
- County Veterans Service Officer
County Investigation: Resources

Example:

- A veteran is treated at the local hospital for a heart attack. He has not been seen in a VA facility in the last 24 months. The hospital files the county assistance application for processing.

- Is the county the payer of last resort? Yes, if he is otherwise eligible. The veteran has not access services in the last 24 months from a VA facility so it is not a resource to the veteran.
County Investigation: Resources

- **CMS 1011 Program**
  - Allows eligible providers to apply for payment of some or all of their unreimbursed costs of providing services required by Section 1867 of the Social Security Act and related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa.
  - Hospital must apply
  - Each state is provided a limited amount of money annually.
EXAMPLE:

- Victor, a 32 year old unemployed individual, received emergency medical services due to an auto accident at St. Daniel’s hospital. At the time the hospital determined that he was an undocumented person and may be eligible for Section 1011 funds to pay for the emergency services. The hospital applied and was informed that funding had been exhausted. They also filed a combined application with IDHW/CAU and was denied.

- Is the county the payer of last resort? Investigate why Victor was denied by the CAU. IDHW may provide services to undocumented for emergency care. *(IDAPA Rules - 229. -- 239.(Reserved) 240. 271 Individuals Who Do Not Meet The Citizenship or Qualified Non-Citizen Requirements.)* Once the emergency is considered over the remaining balance may be sent to the county for processing.
Exemptions exist

11-605(1) - (3), allows for exemption of:

- Value of the homestead of the applicant/obligated person up to $100,000 (55-1003)
- Burial plot
- Up to $750 per item not to exceed $7,500 for all: Household furnishings, goods, and appliances, heirlooms, wearing apparel, books, instruments;
- Up to $1,000 in jewelry;
- $2,500 maximum value of implements, professional books, and tools of the trade;
- One (1) motor vehicles not to exceed $7,000 in value

(Review 11-605 for complete details of this section)
Necessary Medical Services

These slides are intended to provide information on determining necessary medical services by using treatment plans, medical records and reviews, and considering those states who provide services under reciprocal agreements.
County Investigation: Necessary Medical Services

- Defined in §31-3502(18)A
  - In accordance with generally accepted standards of medical practice
  - Provided to a person for prevention, evaluation, diagnosis or treatment of illness, injury, disease or its symptoms
  - Are clinically appropriate and effective
  - Not provided for convenience of patient or providers
  - Are the most cost effective services or supplies.

- Medical Necessity shall be determined by a physician.
Excludes some services: §31-3502(18)B

- Organ or bone marrow transplants
- Elective, or cosmetic or experimental procedures
- Services provided by residential, skilled nursing, assisted living and shelter care facilities
- Normal uncomplicated pregnancies, excludes caesarean section and childbirth well baby care
- Drugs, devices or procedures primarily used for weight reduction or complications
- Medicare/Medicaid co pays and deductibles
- Services provided by state, federal or local health programs
County Investigation: Reciprocal Agreements

- Reciprocal Agreements: §31-3503B
  - Oregon and Utah are the only states where agreements were signed.
  - Emergency services
  - Not reasonably available to Idaho residents
  - No other states fall under this agreement
County Investigation: Treatment Plan

- Outline of the requested services §31-3504(3)
    - Physical therapy, x-rays, lab work, etc.
    - Approved by attending physician
    - Dates of service
    - Approximate cost
    - Location
    - Diagnosis

- Submitted to the county for consideration

- Can be considered if submitted prior to the Board’s initial determination
County Investigation: Medical Records

- Medical Records
  - Review for information, diagnosis, and treatment
  - Treatment Plan
    - Outline of the requested services
    - Physical therapy, x-rays, lab work, etc.
  - Read the medical records! *(See sample Medical records request)*

- Types of records required by CAT
  - History & Physical
  - Emergency Room Report
  - Discharge Summary
  - Operative Report
  - Consultations
County Investigation: Medical Reviews

- Medical Reviews 31-3502(28)
  - Medical Review *(See Order for Medical Review and Submission of Medical Records)*
    - Physician and psychiatrist review
      - Evaluation of medical necessity, length of stay, discharge planning and claims review
    - Send complete records
      - CAT required records
      - Doctor & Nurses notes
      - Lab reports
      - Radiology reports
      - Case notes from the doctor’s office
  - CAT Board Policies (review)
County Investigation: Medical Reviews

- CAT will participate with the counties in the cost of medical reviews conducted on CAT cases as described when:
  - The review is completed as a part of the Board of County Commissioners’ determination process and not after an approval.
  - Any reviewers’ recommendations that provide for a reduction must be considered and if the BOCC chooses not to apply a reduction, the county decision shall explain the county’s choice to pay at the Medicaid rate.

(See next slide)
County Investigation: Medical Reviews… Suggested language

- Based upon the recommendation of a medical reviewer as set forth in Idaho Code § 31-3502(25), 31-3503A, 31-3508, and 31-3519, XXX county has APPROVED for payment, necessary emergent medical services, in the total sum of $24,567.08.

- IF YOU DO NOT AGREE WITH THIS DECISION, you may file a motion for reconsideration with the Board. Pursuant to Idaho Code § 67-5246 and IDAPA 04.11.01.740, a motion for reconsideration must be received by the Board within fourteen (14) days of the service date of this decision. If a motion for reconsideration is not received timely, this decision will stand without further notice pursuant to I.C. § 67-5246. Motions for reconsideration must be in writing and must state all of the specific reasons why the decision is being disputed. Please include copies of all supporting documentation, including medical records, that you would like the Board to consider. The Board will dispose of a motion for reconsideration within twenty-one (21) days of its receipt, or the motion will be considered denied by operation of law. I.C. 67-5246(4). If no response is received a check will be generated for payment.
County Investigation: Medical Reviews

- CAT participation with counties
  - As the payer of last resort, all resources shall be identified and researched as a potential payment source. If the reviewer recommends a source, please follow up on that as well. Written determinations and/or explanations need to be included when submitting a case.
  
- The comparison data provided for information only is being provided for you to use at your discretion when negotiating with a provider’s billing dept. and determining a payment amount with the provider.
County Investigation: Medical Reviews

- CAT participation with counties
- CAT Board Policies
  - All county approved cases above $75,000 are required to have a medical review and counties will be reimbursed for 50% of the review;
  - Counties may conduct medical reviews for CAT cases under $75,000 and would be reimbursed for 50% of the review.
County Investigation: Medical Reviews

Example 1:

- Bulldog County receives application requesting services for an emergency gallbladder surgery. In reviewing the medical records the county discovers that the applicant also received liposuction and was billed as part of the procedure. The charges were in excess of $50,000.

- Should these services be medically reviewed? Yes, because compliance needs to be determined by an expert §31-3502(8)(B)

- Note: In these cases, the question may not be about medical necessity but with regard to what is not covered per statute.
Example 2:

Danny, a 42 year old single unemployed male, had a stint placed in his back for administration of pain medication in 2010. It has since become bothersome and the doctor has submitted a treatment plan and recommends the stint be removed for fear of possible infection. A pre-authorization application is received by the County on January 5, 2012 with an estimated cost of $65,000. Danny has about $300 per month in discretionary income. County requests all case notes from the doctor for the period prior to stint placement through the request for removal time period and submits for medical review.

Are the requested services medically necessary? The medical review determines that while the stint removal may be medically necessary, it is not emergent as there is no infection currently. The patient just wants the stint out. The county denies the application.
Example 1 (continued):

- 6 weeks later county receives a 31 day combined application for the stint removal (same procedure). However, the cost is $6700.00. County denies as not medically indigent

Discussion: *Medical reviews are very valuable particularly for pre-authorizations. Had the county made a determination without medical review, the applicant would have been considered medically indigent for the estimated $65,000 and based upon the wording of the treatment plan and therefore been obligated to pay the $6,700 bill for which the applicant could pay on his own. Questioning the provider, we were told the estimations are based on a worst case scenario.*
Pre-Existing Condition Insurance Plan (PCIP)

The purpose of the Pre-Existing Condition Insurance Plan (PCIP) is intended to assist citizens with no insurance and a pre-existing condition who are in need of medical treatment.

PCIP: Process when applying to other resource, make indigent determination for certain period of time & pay premiums. This is a stopgap measure and expires January 2014.
Pre-Existing Condition Insurance Plan (PCIP)

- Temporary High Risk Health Insurance Pool Program until January 1, 2014 when:
  - Health Insurance Exchanges are established
  - Private insurers may not decline or surcharge people based on health status

- Regular health insurance coverage with two exceptions:
  - There is NO pre-existing condition waiting period
  - The premium rates are limited, and are based on the plan and the age of the participant
Pre-Existing Condition Insurance Plan (PCIP)

- The person must meet the following criteria to be eligible to apply for PCIP:
  - The person must be a citizen or residing in the U.S. legally;
  - The person cannot have had health coverage for at least the last 6 months;
    - Insurance includes Medicaid, Medicare, or any other policy deemed to be a medical insurance policy.
    - Carefully check other policies that only pay the person on a per day basis for hospitalization – these policies list that they are not insurance policies.
  - Have a pre-existing condition or have been denied health coverage because of their health condition (check PCIP Application – Section 4)
Pre-Existing Condition Insurance Plan (PCIP)

- Proof of existing condition requires:
  - A copy of a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months describing the medical condition, illness or disability. This letter must have the physicians signature and their medical license number; **or**
  - A copy of a denial letter from an insurance company for coverage within the past 12 months or a letter stating that the person is not eligible for individual insurance because of the condition; **or**
  - A copy of the individual health insurance coverage with the exclusionary rider; **or**
  - Under 19, a copy of the insurance company’s letter showing the premium for the individual coverage you were offered, but did not accept.
Pre-Existing Condition Insurance Plan (PCIP)

- Applicant applies for regular medical insurance
  - Insurance agent
  - Insurance broker
  - At Blue Cross or Blue Shield local office
  - On the Internet
    - At Blue Cross or Blue Shield website
    - At www.eHealthInsurance.com
    - Other insurance websites
Pre-Existing Condition Insurance Plan (PCIP)

- Denial of Insurance
  - If denied regular insurance, apply for PCIP at [www.PCIP.com](http://www.PCIP.com) website.
  - If regular insurance offers their premium plans and refers applicant to High Risk Pool, this IS a denial
  - If insurance will not cover pre-existing condition for 12 months – this IS a denial
  - Have person apply for PCIP
A person can apply to PCIP in three ways:

- Phone
- Online – a person can apply individually or with assistance from a county or provider by going on-line to the [www.pcip.gov](http://www.pcip.gov) website and assist the applicant with the process if needed
- In writing – a person can print off the application and mail the application and all required documentation to:
  - National Finance Center
  - Pre-Existing Condition Insurance Plan
  - P.O. Box 60017
  - New Orleans, LA. 70160-0017

- Phoning the call center for help completing the application of answering questions:
  - Also try 1-877-829-9562 and select OPT 3 from 7:30 – 3:30 MT.
Pre-Existing Condition Insurance Plan (PCIP)

For additional information:

Go to:
- [www.healthcare.gov](http://www.healthcare.gov)
- [www.hhs.gov/ccio](http://www.hhs.gov/ccio)
- [www.pciplan.com](http://www.pciplan.com)

Visit [www.pciplan.com](http://www.pciplan.com) for resources and information about the federally-run PCIP, administered by GEHA:
- View plan materials
- Search for or nominate your provider
- Search you prescriptions

Call Customer Service: 1-800-220-7898 (7:00 a.m.-5:30 p.m. Central Time) Monday-Friday (except holidays)
Pre-Existing Condition Insurance Plan (PCIP)

Eligibility – Effective date of coverage:

- It is very important to realize that the effective date of coverage is determined from receipt of a COMPLETED application.
  - If the completed application is received on or before September 15th, they then should become eligible October 1st. If the completed application is received September 16th they would become eligible November 1st.
  - Application received Jan. 19th, PCIP letter generated for supporting documentation issued Feb. 23. Supporting documentation received March 5th at PCIP. March 5th is date of completed application. Effective date is April 1.
Pre-Existing Condition Insurance Plan (PCIP)

- Request for Earlier Coverage – Effective Date:
  - Applicant files on Sept 17, applicant can request in writing upon receipt of approval date and within 14 days, consideration for retro eligibility to Oct. 1 instead of the automatic date of Nov 1. That is the earliest that coverage can take place.
    - Fax number: 1-303-205-3373 to request an earlier date.
  - Applicant cannot seek retroactive coverage to September 1.
  - Once enrolled in one of the plans, you cannot change plans. Cannot switch from Extended to Standard without canceling your policy and reapplying.
Pre-Existing Condition Insurance Plan (PCIP)

- **Benefits or Features**
  - Care in medical offices for treatment of illness/injury
  - Emergency Services
  - Inpatient & Outpatient hospital services
  - Inpatient & Outpatient mental health/substance abuse
  - Prescription drugs (some medications and treatment may require prior authorization)
  - Home Health and hospice services
  - Outpatient laboratory and diagnostic services
  - In- and out-of-network benefits
    - Idaho is classified as a medically underserved state. This does NOT mean all providers are in network.
Pre-Existing Condition Insurance Plan (PCIP)

- Benefits or Features (continued)
  - First dollar coverage for preventative care
  - No lifetime maximum on the amount the plan pays for enrollee’s care
  - Benefits available immediately when coverage begins, even for pre-existing conditions
  - The ability to receive benefits at any qualified provider
    - Remember if the person is on PCIP and another medical need arises, they are still covered under this plan.
Pre-Existing Condition Insurance Plan (PCIP)

How this works for Indigent Program

- County or hospitals assists individual in applying
- Identify participants based on need for future medical service.
  - Likely may have had services rendered but ongoing care would be needed
  - Chronic, ongoing medical conditions, i.e., Crohns, diabetes, heart, etc.
  - Lengthy course of treatment, i.e., Cancer, Hepatitis C, etc.
Pre-Existing Condition Insurance Plan (PCIP)

- Work with the local hospital on the PCIP program.
  - Is your local hospital willing to submit the application to PCIP for the patient?
  - Is the local hospital willing to make the 1st month premium payment and then turn it over to county?
  - Is the local hospital willing to work with the patient regarding the deductible and co-pays?
  - This is a win for the hospital, PCIP pays more than county.
Pre-Existing Condition Insurance Plan (PCIP)

- To receive financial assistance for premium coverage from the county or state CAT fund:
  - The person will need to be determined to be indigent;
  - If approved by PCIP, then payment must be sent within 30 days of the date of the approval letter; future premium payments must be received by the 1\textsuperscript{st} of each month;
  - If the payment is not received within 30 days of the date of the approval letter, the individual must then reapply for PCIP.

- During county approval make a determination how long the county will pay premiums (month to month, 3 months, 6 months)
Pre-Existing Condition Insurance Plan (PCIP)

- It can become complicated. Applicant can be deemed disabled by SSA. Medicaid retro covers. SSI then approves and monthly income now puts the person over income for Medicaid. Medicaid now stops, leaving the person without Medicaid and without PCIP coverage.

- Requests for PCIP assistance can come on a 31 day application along with other providers and dates of service or on a 10 day prior application where only PCIP is the requested assistance.

- It is important that any and all applications be submitted to IDH&W Combined Unit for a determination. There is only one recognized application. DO NOT use older versions of the county application.
Pre-Existing Condition Insurance Plan (PCIP)

- Only those requests on a combined application will be considered by the CAT board for reimbursement.
  - See CAT Policy: The CAT program may require that a medical review be performed

- Use the PCIP Authorization to Disclose Protected Health Information. *(See PCIP Release Form)*
  *(Without this release, PCIP will NOT discuss anything with you. ALWAYS keep a copy of the application and supporting documentation. ALWAYS send the application via CERTIFIED MAIL RETURN RECEIPT.)*
Pre-Existing Condition Insurance Plan (PCIP)

- Highly recommend that the applicant apply for SSD/SSI when there is a diagnosis warranting such. (Cancer, etc.)
  - Some of the cancer cases are being turned by SSA in less than 2 months. Medicaid could then be an option for your client.
- Take charge of your client's application, call for status, account numbers, and medical ID numbers. If you stay on top of the application process you can avoid mistakes and delays that could result in your county paying the lion's share of expenses BEFORE PCIP starts.
- PCIP can save the county, state, and patient a lot of money.
- Look at the cost of treatment, especially on a 10-day prior.
- Not all cases will fit into the PCIP scenario.
Pre-Existing Condition Insurance Plan (PCIP)

- PCIP is insurance and requires prior authorization on some services and prescriptions—providers will need to call for inpatient and other services prior to the provision of services.
- Account numbers are assigned upon receipt of application. Premiums are paid by account number.
- Medical ID numbers are assigned upon payment of premiums. Medical ID numbers are required for the pre-auth services. Medical ID’s are assigned weekly when PCIP does the transfer to GEHA each Wednesday.
- If the person needs assistance with the premiums, file a 10-day prior combined application to get the determination and then be able to send in the premium upon approval.
Pre-Existing Condition Insurance Plan (PCIP)

Example 1: 10 day prior to coming to county

Bob is a single 50 year old male and needs back surgery. He does not have the money to pay for the surgery and applies to the county for assistance. This problem has been ongoing for years and several discs need to be repaired. Bob has been uninsured for several years. He can return to work once recovered from the surgery. The surgery is not an emergency, but is medically necessary.

What would be the best option for Bob? Bob could apply for PCIP. He has not had insurance in the last 6 months, he can return to work and the county could seek reimbursement for the PCIP which is less costly to Bob to repay.
Pre-Existing Condition Insurance Plan (PCIP)

Example 1: 10 day prior to coming to county

- Again look at the cost of the treatment vs. the cost of PCIP.
- Let's say the person is looking at $150,000 with an interim rate of say $75,000 vs. PCIP at $424 per month for 6 months and your repayment is $75 a month.
- Which scenario is more likely to be repaid.
  - $75,000 repaid at $75 a month will take 83 years to repay.
  - $2,544 ($424*6 mo) repaid at $75 a month will take 2.8 years to repay.
Pre-Existing Condition Insurance Plan (PCIP)

Example 2: 31 day emergency filed at hospital

- Harriett is a single 31 year old female. She was admitted to Ponderosa Hospital in Goodwood county, Idaho for diabetic ketosis. Harriett has been a diabetic for years, but has poor control. She has been in and out of the hospital several times over the last year. She has not had insurance for the last 6 months and works as a waitress at the local rib house. Her hospitalization costs are beyond her means and an application was filed with the county.

- What is the best recourse for Harriett? The county would need to process her emergency application to determined her eligibility for county assistance. Due to her poor control of diabetes a PCIP application may be the best option.
Pre-Existing Condition Insurance Plan (PCIP)

Example 3:

Alice entered the ER at Lucky Hospital and was diagnosed with a large tumor. Emergency surgery took place. She will need aggressive chemo and radiation treatment after healing from surgery. A 10 day prior application was submitted to the county for the upcoming treatment, to begin 2 weeks after the filing of the application. During the interview the county discussed PCIP insurance. Alice has already filed for SSI and been denied once and she has already appealed. Alice has a good work history, but no income right now. It is very possible she will be eligible for Idaho Medicaid for about 6 months, but when she receives her SSD she will become over income for Medicaid. It will be an additional 18 months when her Medicare is available. The treatment plan indicates she will need care for at least a year or longer.

Should the county pay for PCIP? Yes, Alice’s treatment will continue past her Medicaid eligibility period. It is important not to drop the PCIP coverage as she will not be eligible to reapply to PCIP for 6 months after the payment is discontinued and she is also not eligible for Medicare for 18 months. If county drops coverage they may become the responsible party for payment of her medical care until another resource is available (PCIP or Medicare).
Board of County Commissioners Determination

The following slides are intended to give you an overview of the Board of County Commissioners (BOCC) determination process for approved, denied and suspended claims. These slides also include the BOCC decisions, violations and penalties, reimbursement, appeals and pre-litigation processes. The clerk’s statement for the BOCC and the timeframes for completion of the application process are included.
Board of County Commissioners: Clerk’s Statement

- Clerk’s Findings §31-3505A(6)
  - Review with prosecuting attorney if necessary
  - Prepare statement of findings
    - Summary of applicant’s personal information, residency, requested billings, treatment or care received or requested, income, expenses and ability to pay the debt within 60 months
    - Listing of all assets and net value
    - Statement of other identified resources
    - Clerks Recommendation for approval, denial
    - Recommendation for reimbursement
    - Pertinent comments BOCC may find helpful in making their decision
Board of County Commissioners: Clerks Timeframes

- Submit findings to the BOCC for their determination of eligibility
- 20 Days from receipt of application: Non-emergency §31-3505A(3)
- 45 Days from receipt of application: Emergency §31-3505A(4)
- 10 Days from receipt of request: Request for additional treatment related to original diagnosis §31-3505A(5)
- Upon completion of the interview and investigation a statement of the clerk’s finding shall be filed with the county commissioners. §31-3505A(6)
Board of County Commissioners: Initial Determination

- Initial decision by the board 31-3505C
  - Occur within 15 days of receipt of clerks statement
  - Occur within 5 days of clerk’s statement on a request
  - Mailed to applicant and all parties listed on page 1 of the combined application
    - During the interview process additional providers may be included for consideration by the BOCC as per the applicants request
    - Mailed within 5 days of decision

- (See Sample County Approval and Denial Forms)
Board of County Commissioners: Violations and Penalties

- §31-3511
- County may deny application
- False and misleading information by applicant
  - Does not disclose insurance, worker’s comp, other resource or benefits; failure to disclose assets that may render them not medically indigent
  - Failure to cooperate
  - If applicant divests themselves in order to qualify
  - If sanctioned by a state program they are also ineligible for county assistance for the same time period
- BOCC fails to make a timely decision; result is an automatic approval
- Applicant/providers may appeal
The BOCC shall approve an application if it determines: §31-3519

- Necessary medical services were provided
- The applicant is a resident, cannot pay over a five year period and has no other source of payment; has cooperated with the county and the application was timely filed.
- The obligated county paid the first $11,000; the services when paid at the reimbursement rate exceeds the total sum of $11,000 and then becomes payable by the CAT
- Payment to provider shall be payment in full and provider Shall not seek additional payment from the applicant §31-3519(2)
Board of County Commissioners: Approved County Claims

- Bills less than $25.00 shall not be presented for payment if only one bill is presented by the provider. **31-3508**

- In some cases bills less than $25 each may still be submitted if the claims for the approved dates of service are consecutive. Example: $24 DOS 1/25/12, $24 DOS 1/26/12 total $48.00

- Any reviewers’ recommendations that provide for a reduction must be considered and if the BOCC chooses not to apply a reduction, the county decision shall explain the choice to pay at the Medicaid rate.

- Currently counties shall not pay more than 95% of the adjusted Medicaid rate.
Board of County Commissioners: Approved County Claims

- Upon receipt of a final determination approving the application, the applicant or third party applicant shall within 60 days submit a medical claim (§31-3502(15)) to the county pursuant to the procedures provided in chapter 15, title 31, Idaho Code. §31-3508A

- Medical claims received after the 60 day time frame shall not be paid by the county provided the provider received notice of the approval.

- County payment shall be made to providers on behalf of an applicant on the next payment cycle. In no event shall payment be delayed longer than sixty (60) days from receipt of the county claim.
Always check applicable Hospital interim rate

- Sent to Clerks and Indigent Directors by IAC 4-5 times per year;
- Or on IAC’s website: [http://www.idcounties.org](http://www.idcounties.org)
  Click “About IAC”, “Affiliates”, “Indigent” then “Interim Medicaid rates”
- Check to make sure you have printed all pages/tabs
Board of County Commissioners: Approved County Claims

- Payment to provider shall be payment in full and provider Shall not seek additional payment from the applicant §31-3508A

- The clerk shall forwards claims in excess of $11,000 to the CAT within fourteen (14) days of county payment. 31-3508A

- Failure by the provider/applicant to send bills within 60 days will result in no payment.
  - *District Court Case: St. Joseph RMC vs. Nez Perce County*
Payment of claim:

The county and CAT shall be subrogated to all rights of the hospital, other providers, and medically indigent person against any third parties who might be the cause of or liable for such medical services. §31-3510

(See CAT Process in later slides)
Board of County Commissioners: Reimbursement

- Work with the applicant – Unexpected Circumstances
  - Resources/Referrals
    - RX programs
    - Federally Qualified Health Centers (FQHC)
    - Credit Counseling Services
    - Vocational Rehabilitation
    - Veteran Services
  - Collect over a *reasonable* period of time
  - Signed promissory note and payment arrangements
    - Explain the process
    - *(See Sample Promissory Note and Payment Agreement)*
Board of County Commissioners: Reimbursement

Receipt of financial assistance pursuant to this chapter of Idaho Code shall obligate the applicant(s) to reimburse the county and the CAT program from which assistance is received:

- Automatic liens
- Promissory note
- County shall have the same right of recovery
- Lien released upon satisfaction
Board of County Commissioners: Reimbursement

- Applicant may increase reimbursement on an ongoing basis payment – if BOCC determines a substantial change in circumstances has occurred

- BOCC may review a petition from applicant to reduce order of reimbursement on substantial change in circumstances
Board of County Commissioners: Reimbursement

Example:

- Anna is a single 21 year old female who received assistance from Oxbow county, Idaho for surgery on her hand. She recovered fully and returned to work.

- Should the county seek reimbursement from Anna? Yes, §31-3510A obligates an applicant to reimburse the county for receipt of financial services. The county should setup a reimbursement plan that fits her budget.
Board of County Commissioners: Suspensions

- Creates process for pending resources §31-3505C(2)
- Pending resources must be sole basis for holding up an application from full approval. The application/applicant meets all other criteria for county medical assistance.
  - Other forms of public assistance
    - Crime victims
    - Worker’s comp
    - Veterans
    - Medicaid or Medicare
    - SSI
    - Third party or other insurance
- Application suspended – tolls all time limits §31-3505C(3)
Board of County Commissioners: Suspensions

- Applicant deemed eligible for resource:
  - If notified that patient is subsequently determined to be eligible for a pending resource, notify the providers listed on the application. This would be communicated in the form of a denial that the patient is eligible for the resource on the date specified and that the county no longer is the last resource. §31-3505C (2)(a)
  - *(See Sample Suspension Letter)*

- The provider must apply to that resource.

- If there is another resource, the county must exhaust all efforts to check that resource, including contacting Social Security and staying in contact with the provider facility.
EXAMPLE 1:

James is a single 44 year old male. He was injured in a single rollover vehicle accident which resulted in severe injuries to both of his legs. He did not have any automobile insurance. James applied for SSI and Medicaid which was pending at the time of the county assistance application. He has had very low wages over the last 10 years. The county suspended his application pending the outcome of SSI and Medicaid.

Discussion: James was awarded SSI and Medicaid which provided coverage for his hospitalization and ongoing care. The county notified the providers of the approval and beginning date for Medicaid to allow them to bill Medicaid for the requested service dates.
Board of County Commissioners: Appeal Process

- Appeal must be received by the county within 28 days of the date of the initial denial §31-3505D
  - Deadline falls on a weekend or holiday, appeal must be received next business day (73-109; 110; Idaho Rules of Civil Procedure 6A)

- Decision becomes final if appeal is not filed with county within 28 days of the date of the denial
Board of County Commissioners: Appeal Process

- Hearing is scheduled within 75 days of the receipt of request for hearing §31-3505E
- Usually a provision within an appeal from a provider
- Hearing notice shall be mailed to:
  - Applicant
  - All providers listed on the application

- The clerk shall prepare copies of exhibits and clerk’s findings for board of county commissioners, prosecuting attorney and opposing counsel.

- Continuations of the hearing:
  - 1st 45 days from the date of the hearing to allow for additional information to be provided
Board of County Commissioners: Appeal Process

- Continuations of the hearing continued:
  - Additional continuation must be by stipulation between BOCC and applicant.

- The board’s final determination must be made within 30 days of the conclusion of hearing.

- Within 5 days of final determination a copy of the decision shall be mailed to the applicant and all providers listed.

- Applicant/provider may seek Judicial Review (§31-3505G) for an adverse decision in the manner provided by §31-1506.
Board of County Commissioners: Appeal Process

Adopt county hearing preparation procedure, ordinance, or resolution

- Each county should develop a hearing procedure
  - Disclosure order, Witness & Exhibit List
  - Subpoena’s
    - County issues subpoena, but the requesting party submits to the sheriff and may be subject to services fees

- Check with some of your colleagues to develop a procedure
County Pricing Guidelines

The following slides provide basic county pricing guidelines to assist county pricers in pricing medical claims correctly. The information is taken from Idaho DHW:

Provider Handbook
Medicaid Fee Schedules
Medicaid Information Releases
Medicaid Newsletters

www.idmedicaid.com
www.healthandwelfare.idaho.gov
County Pricing Guidelines
Acronyms, Terminology, Descriptions

- **UB-04** – Uniform Billing for hospital medical claims
- **HCFA/CMS-1500** - Medical claims used for billing by physicians, radiology departments, and other non-hospital providers
- **DOS** – Dates of Service
- **DOC** – Dates of Coverage
- **DX** – Diagnosis, symptoms, cause of death.
- **ICD-9 converts to ICD-10** – Currently the medical industry is transitioning from ICD-9 to mandatory ICD-10 by October 2013.
  - **ICD-9** - Angioplasty has 1 diagnosis code (39.50).
  - **ICD-10** - Angioplasty has 854 different diagnosis codes
HCPCS - Healthcare Common Procedure Coding System - appears on hospital and physician medical claims. Medicaid doesn’t pay by the HCPCS if there is a comparable CPT code unless it’s on the fee schedule.


Revenue Code – appears on a UB-04 hospital medical claim. Determines payable or non-payable reimbursement and the reimbursement method (1) by interim percentage rate or (2) by HCPCS/CPT code. Revenue codes list is in the County Pricing Guidelines Manual.
County Pricing Guidelines
Acronyms, Terminology, Descriptions

- **Molina Healthcare** – third party administrator contracted to manage Idaho’s Medicaid billing and reimbursement systems.
- **Idaho MMIS** – Idaho Medicaid Management Information System
- **SNF** – Skilled Nursing Facility
- **DHW** – Department of Health and Welfare
- **IDHW** – Idaho Department of Health and Welfare
- **ASC** – Ambulatory Surgical Center
- **HIPAA** – Health Information Portability and Accountability Act, to assure privacy in regards to medical records, including electronically filed medical records to protect the patient
Modifiers—usually a two digit or alpha or a combination of both following a CPT code that may mean one of two things:

1. Informational – provides information regarding the procedure. Price the CPT code as if there was no modifier (Ex: F3 – Left hand 4th digit – no affect on pricing)

2. Pricing – affects reimbursement payment. Ex: Modifier 80 or AS – assistant surgeon reimburses at 20% of Medicaid allowable rate

TC Modifier – Indicates the Technical Component is reported separately from the PC. TC modifies the equipment and technician performing the test and is usually billed on a hospital UB-04 medical claim.

PC/26 Modifier – Professional component is the interpretation (reading) of the results of the procedure and is billed on a HCFA/CMS-1500.
County Pricing Guidelines
Modifiers

- The Modifier Code List in the County Pricing Guidelines Manual lists the modifiers that affect pricing as well as the description of many informational modifiers. Use the list to identify and determine if the modifier is informational or pricing, and reimbursement instructions.

- If modifiers are not in the County Pricing Guidelines Manual and you would like to know what they mean, Google the modifier. Enter “medical modifier Q6” to find several websites that give a description.

- Always price the first modifier first and the following in order.

- Ex: CPT code 64885 with modifiers 80/51

  - 64885 reimburses at $953.27, modifier 80 means reimburse at 20% of allowable rate and 51 means it’s the second procedure, reimburse amount at 50%.

  - $953.27 x 20% = 190.65 x 50% = $95.33

- Until July 1, 2013 multiply the balance by 95%
County Pricing Guidelines
Inpatient/Outpatient Hospital Claims
Overview

- Review medical records and county approval to verify the billed dates of service and the approved dates of service are the same. Deny any dates of service not approved.

- Use the current Revenue Codes List and the Medicaid Fee Schedule when pricing current medical claims. Keep the old schedules to aid in pricing older claims that have been approved after being appealed, suspended, etc. and may have old dates of service.

- Compare the itemized statement with the UB-04 hospital medical claim before calculating to be sure the itemized line items are the same as the billed line items on the UB-04.
Pricing Guidelines
Inpatient Hospital Claims

- An easy way to tell if a hospital claim is inpatient is to look for a room charge.
- Determine the hospital interim percentage rate for reimbursement by using the rate chart provided by IAC periodically and also posted on the IAC website found at http://www.idcounties.org
- Use the current Revenue Codes List found in your County Pricing Guidelines Manual to determine if revenue codes are payable or non-payable. Inpatient codes are in the 4th column titled “Inpatient” and have an “X” if payable.
- Tip: Revenue code 636 is not covered on an inpatient hospital claim
County Pricing Guidelines

Inpatient Hospital Claims

- Do not assume that all revenue codes are paid on an inpatient hospital medical claim. Check the Revenue Codes List and deny any non-payable codes before calculating.

- Deduct the non-payable amounts from the billed amount.

- Multiply the balance by the hospital interim percentage rate to calculate the hospital reimbursed amount.

- *Until July 1, 2013 multiply the balance by 95%*  

- If the county is paying a portion of the hospital medical claim and the balance is forwarded to the CAT Fund, note on the medical claim which portions are paid by each. Show the 95% rate adjustment on the hospital medical claim so CAT will know it has been adjusted.
Outpatient hospital pricing requires more time to calculate because each line item has to be calculated separately for reimbursement, whereas an inpatient hospital claim is reimbursed by the interim percentage rate after subtracting non-covered revenue codes.

Determine the hospital interim percentage rate for reimbursement by using the rate chart provided by IAC and also posted on the IAC website found at http://www.idcounties.org.

Use the current Revenue Codes List in the County Pricing Guidelines Manual to determine if revenue codes are payable or non-payable. Outpatient codes are in the 5th column titled “Outpatient”. An “X” designates the revenue code is to be reimbursed by the hospital interim percentage rate. Revenue codes with CPT/HCPCS in the column designates reimbursement by CPT/HCPCS.
Calculate all the revenue codes reimbursed at the hospital interim percentage rate.

Calculate the CPT/HCPCS codes using the current online fee schedule (or an archived schedule for older medical claims).

Most hospital radiology CPT codes have a TC modifier. The CPT/TC code is reimbursed using the column titled “Technical Component Amount” on the fee schedule.

Tip: A HCFA/1500 medical claim from the radiologist with the same CPT code and a 26 modifier for the radiologist portion should match the DOS and CPT on the hospital medical claim.
County Pricing Guidelines
Outpatient Hospital Claims

- Most lab codes in the 300 series with 8000 series CPT codes are reimbursed 2% more using the following formula after having totaled all codes or one at a time if you prefer:

  \[
  \text{Amount} \times 0.60 \times 62\% \\
  \text{Ex: } 18.31 \times 0.60 = 30.52 \times 62\% = 18.92 \text{ (.61 more)}
  \]

- Do not multiply the calculated CPT codes amount by the hospital interim percentage rate.

- Add the calculated interim percentage reimbursement rate and the calculated CPT code reimbursement rates together for the allowed hospital reimbursement rate and payment.

- Until July 1, 2013 multiply that rate by 95% for the final reimbursement rate to the hospital. 31-3502(23)
County Pricing Guidelines
HCFA/CMS-1500 Physician Claims

- Use appropriate Medicaid Fee Schedule located on the [www.idmedicaid.com](http://www.idmedicaid.com) website for pricing medical claims. The Numerical Fee Schedule is used for pricing most claims (lab, radiology, physician, ambulance, etc.) Dental, Anesthesia, ASC have their own schedules.

- Note the number of days or units in the “G” column of the HCFA/1500 and reimburse for all units billed if within the approved dates of service.

- Radiology medical claims without a modifier PC/26 are reimbursed using the column titled “Allowed Amount” on the fee schedule which means they get the entire amount and do not have to split with the hospital.

- Anesthesia medical claims are reimbursed by the CPT code using column title “Base Units in Minute Increments” on the Anesthesia Fee Schedule. Add that number to the units/minutes in the “G” column on the HCFA/1500 and multiply by $1.03 (per minute reimbursement rate).

- Ex: CPT code 00164 has a base of 60. HCFA “G” column has 120 minutes. 
  \[ 60 + 120 = 180 \times 1.03 = 185.40 \]
Hospital owned air ambulance medical claims are billed on an outpatient hospital claim and reimbursed at the outpatient hospital interim percentage rate using the Medicaid Fee Schedule.

Private owned air ambulance medical claims are billed on a HCFA/1500 and reimbursed by CPT codes.

Ground ambulance medical claims are billed on a HCFA/1500 and reimbursed by the CPT code.

Calculate the number of miles in Box “G” by the current per mile reimbursement rate for both the private owned air ambulance and ground ambulance using the Medicaid Fee Schedule.

Until July 1, 2013 multiply the above reimbursement rates by 95% for the final reimbursement rate to the provider. 31-3502(23)

Use the Dental Fee Schedule for pricing dental medical claims.
County Pricing Guidelines
Skilled Nursing Homes (SNF) & Home Health Services

- Home Health skilled nursing visits are billed on a hospital claim using revenue code 551 with a reimbursement rate of $102.92 per day. Supplies are reimbursed at 100%.

- A Skilled Nursing Facility (Nursing Home) is billed on a hospital UB-04 medical claim. Rates usually change every quarter. Call the facility to get the room rate. The daily rate includes all ancillary charges such as over the counter medication, medical and hygiene supplies, transportation and equipment (wheelchairs, walkers, oxygen rentals, etc.)

  1. Multiply the room rate by the number of days for reimbursement amount
County Pricing Guidelines

- The Medicaid Fee Schedule may show “0” on some covered codes which will need manual pricing. Medicaid has an on-site medical staff to determine the reimbursement rate. Counties have to negotiate reimbursement. Suggestions are:
  1. *Determine the amount your county is willing to pay – 20%, 30%, 40% etc. and offer that amount to the provider.*
  2. *Have the provider send reimbursement proof from Medicaid with the same CPT code and reimburse at that same rate*

- It may take a year or more for Medicaid to price a “0” CPT code. The provider doesn’t want to wait that long for payment, and the county doesn’t want the outstanding payable tabled for later. Fair negotiations usually work best.
Order of Commitment and Fixed Costs for involuntary mental health claims are paid at the full billed amount rate if there is no contract in place with the facility.

Contracts with mental health facilities are encouraged and save the county money.

Reimburse for the days leading up to the day of the court appointed commitment. The IDHW will cover the patient after the commitment date.

Involuntary commitments with amounts over $11,000 are not forwarded to the CAT fund. The county is responsible for the entire reimbursement amount 66-327
County Pricing Guidelines
Prescription Drugs

- The Idaho Medicaid Pharmacy unit changed its reimbursement methodology in September 2011. The County Drug File schedule will be removed from the Medicaid website in time. Do not use it.

- To price prescription drugs a new website is established using the average actual acquisition cost. (AAAC) This is updated at least weekly and reflects what is currently reimbursed to a pharmacy for an individual drug.

- Every pharmacy is assigned a Medicaid dispensing fee of at least $11.51 – up from the previous dispensing rate of $4.94.

- Tip: Most pharmacies don’t seem to know what their reimbursement rate is. Counties have no way of knowing so $11.51 dispensing rate is appropriate until the pharmacy notifies the county differently.
County Pricing Guidelines
Prescription Drugs

- Identify the drug name and dose and if it’s generic or brand. NDCs are not needed. Ex: there may be 4 different NDCs for Abilify 5 mg - all pay the same.
- Go to the website http://id.mslc.com/
- Click on “Pharmacy” on the left hand side of the page
- On the next screen the choices are displayed under AAAC list
- Select the checked box of choice in either the generic or brand section
- The AAAC list the cost per tablet, capsule, each or ml. depending on the dosage form.
- Multiply the quantity by the price and add $11.51 for the final price.
- Ex: Brand name Doxepin 75 mg is .25399 per capsule
- 10 X .25399 = 2.54 + 11.51 = $14.05 total reimbursement
- Tip: Pharmacies may complain that the per pill price is less than cost but that’s the way it’s set up and the increased dispensing fee balances it out.
County Pricing Guidelines

Tips

- Hospital bill type code is in the upper right corner of the claim in Box 4.
- Base rate for hospitals not listed on the hospital interim percentage list is 80% for outpatient and 75% for inpatient.
- Some DME rental supplies (RR) are now priced at a forever price and do not need to be divided by the 10 months method as done in the past. Ex: On the July 2011 fee schedule, oxygen tank E0431 reimburses at $25.87 as long as needed. On the January 2011 schedule it was $287.70 divided by 10 for a reimbursement rate of $28.77 for 10 months and then the tank was considered owned by the county.
- If the reimbursed amount on July 2011 fee schedule is much less than on January 2011 fee schedule it is most likely a per month fee. Do not divide by 10. Requires some price comparison/research on some of the codes to determine if reimbursement is forever or divided by 10 months.
ASC rates are no longer used to reimburse hospitals billing with 360 and 361 revenue codes and payable CPT codes. Previously the hospital was reimbursed by the CPT code. Now all outpatient hospital medical claims using 360 and 361 revenue codes are to be reimbursed by that hospital’s interim percentage rate unless the hospital notified Molina that it is a hospital based ASC.

Kootenai Medical Center is the only known hospital owned ASC (per Medicaid)

Continue to pay stand alone ASCs using the ASC fee schedule

Trauma hospital revenue codes in the 600 range are non-payable. 680 is the most commonly billed.
10.5.1 - *Air ambulance services are covered when one of the following occurs:*

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential.
- The participant’s condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance. (Page 40)

3.4.2. *Exceptions (Private vs. Semiprivate hospital room reimbursement)*

- Payment is limited to a semiprivate room accommodation rate except when an isolation room or private room is medically necessary and ordered by a physician, Medicaid will then pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form. (Page 5)
4.6. Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology) *(4.6.3. Limitations)*

- PT visits are limited to 25 visits per calendar year regardless of the billing provider.
- OT visits are limited to 25 visits per calendar year regardless of the billing provider.
- Speech-language pathology visits are limited to 40 visits per calendar year regardless of the billing provider.
- The county pricer must keep track of visits, especially if the patient changes therapists.
- Effective January 2012, outpatient PT/OT/Speech-Language are no longer reimbursed at the hospital interim percentage rate, reimburse by the CPT code listed on the medical claim. Continue to reimburse inpatient at the interim percentage rate. *(Page 12)*
4.3. Outpatient Observation

- When a participant is observed in an inpatient bed by staff assigned to the routine care area, revenue code 0760 or 0762 should be used to reflect the costs of the routine service area. Any participant who is in observation status in a routine service area after 24 hours must be admitted at the beginning of the twenty-fifth hour. (Page 10)

- Idaho Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee established by the Idaho Department of Health and Welfare Division of Medicaid, whichever is lower. (H&W website front page)

- Tip: On medical claims that are billed less than the Medicaid reimbursed rate is, pay the billed amount.

- Tip: The Medicaid Provider Handbook is found at www.idmedicaid.com
For questions regarding pricing medical claims which are not addressed in these slides or the County Pricing Guidelines Manual please contact your district pricing trainer or the state pricing trainer. Medicaid/Molina prefers that only one person contacts them for pricing, otherwise they would be answering the same questions over and over. The ideal way is:

1. Contact the district or state trainer directly
2. If it is a major update/change, the state trainer will send an email to all the counties updating the issue
3. New county pricers need to remember that it’s okay to ask when they need help. Medical claims pricing is on the job training.
4. Do NOT opinion shop. It will ultimately slow you down. Contact the trainer first.
Pre-litigation Screening Panel

The legislature has established these sections to encourage the non-litigation resolution of claims between the counties and health providers by providing for pre-litigation screening of such claims prior to judicial review. The three-member panel is independent and the recommendations of the panel are non-binding. §31-3551-3557
Pre-litigation Screening Panel

- Pre-litigation was developed to provide guidance in contested resource availability cases §31-3551
- An advisory panel is formed to act as a special civil grand jury and provide a procedure for pre-litigation
- The panel consists of three (3) members – all serve under oath they are without bias or conflict of interest §31-3552
  - Chairman – representing and appointed by Health & Welfare
  - One (1) Member – representing and appointed by the Idaho Association of Counties
  - One (1) Member – representing and appointed by the Idaho Hospital Association.
Pre-litigation Screening Panel

- The pre-litigation panel meets about 4 times per year and typically reviews 8-10 cases to initiate a panel meeting.
- Pre-litigation precedes any court action and is non-binding
- All panel meetings are recorded and minutes created. Minutes are sent to all participants for review after conclusion of the case
- The panel will consider the eligibility of the applicants on claims referred to them and render a written decision based on an analysis of the resources available to the applicant
Pre-litigation Screening Panel

- The appealing party may submit an appeal to the Department of Health and Welfare for pre-litigation review within 28 days of a county denial that is based on available resources.
- The County will be sending the transcript and certified copy of the record to the pre-litigation panel, appealing party and the county prosecuting attorney via Health & Welfare.
- The appealing party will request and pay the County for preparation of the hearing transcript.
- When the Pre-litigation Panel is notified, the applicable statute of limitation is tolled and not deemed to run during the time the claim is before the panel and for 30 days thereafter. §31-3554
Pre-litigation Screening Panel

- An appeal to district court is commenced by filing a petition for judicial review within twenty-eight (28) days of the Board’s final determination
  - *** The clerk of the board is responsible to prepare the record using the Idaho Rules of Civil Procedure (Within 42 days)

- If a copy of the transcript is requested, the clerk of the board must prepare one with cost for the preparation to be paid by the appealing party
Pre-litigation Screening Panel

- Contacts:
  - Patti James, Administrative Assistant (scheduling, transcripts and coordination)
    - 208-334-5815  jamesp@idhw.idaho.gov
  - Mailing address – 450 West State Second Floor,
    - Boise, Idaho 83720-0036
  - Shannon Epperley, IDHW (Committee Chair)
    - 208-334-5784
Pre-litigation Screening Panel

- IDHW Representative:
  - Patti James (Chair), IDHW

- County Representative:
  - Michele Sherrr, Gem County Commissioner

- Hospital Representative
Catastrophic Health Care Cost Program: (CAT Fund)

The next group of slides will explain the Catastrophic (CAT) process from the electronic submission of the case through the Board’s approval and payment of the claims by the state Controller. *(See CAT History)*

The CAT program contracted with Security Connections Inc. (SCI) to enable counties to electronically submit cases and enable IDHW/CAU to electronically notify counties of denials and upload the applications.

*(See SCI Sample Spreadsheet and SCI FAQ’s)*
Catastrophic Fund: Application

- CAT Application is online at: www.idcounties.org, “CAT Programs,” “Forms”

- Following information is required: *(See CAT Application)*
  - CAT number and submitting county
  - Anniversary date (1 year from when services were received)
  - Application type
  - Monthly Income and major assets
  - Nature of Emergency and subsequent treatment
  - Total billed charges; total at Medicaid rate
  - Medical Review information including recommendations
  - Other resource information
Catastrophic Fund: Electronic Case Submission

- Catastrophic application must be submitted electronically
  - Only one CAT application per CAT Year
- Copy of each uniform combined application and treatment plan
- Medical records & bills (doctor’s reports, ER reports, treatment, etc.)
- Every county determination (includes denials, orders, legal docs if approval made as a result of a hearing or a Judge)
- Decisions from 3rd party payers & verifications from other resources, such as: with Medicaid, SSI, Medicare, Liability Insurance, Worker’s Comp, Crime Victims benefits, Auto Insurance, Homeowners Insurance.
Catastrophic Fund: Electronic Case Submission

- Copy of lien, UCC-1 (N1 form), promissory note/order of reimbursement
- Other relevant documentation
- County Payment Form
  - List all providers, billed amounts, etc. as paid by the County – must submit case to CAT within 14 days of payment of the deductible.
  - Attach each bill in order behind the payment form.
  - Show the pricing methodology on the bills. (Hand writing is fine)
  - If combining county cases to submit a CAT case- group the bills from each county case together. Add together on the County cover sheet for payment.
Catastrophic Fund: Electronic Case Submission

- Catastrophic fund payment form – *Must have the CAT number on it.*
  - Group each provider together, (sort by provider, then by DOS), include billed amounts, and priced amounts you are requesting the Catastrophic fund pay.
  - Start a new request form when scanning ongoing bills to CAT after application with the CAT has been made. Group as many bills as possible on each sheet.
Catastrophic Fund: Electronic Case Submission

- CAT payment request summary sheet requirements:
  - CAT Number
  - Anniversary date (expiration date)
  - Sort by Provider …then Date of Service (DOS)
  - Bills in order behind summary sheet
  - Do not combine bills into one line (Hospitals)
  - Do not stack separate requests for payment with bills on top of each other
Catastrophic Fund: Electronic Case Submission

- Send Bills to the CAT for payment if:
  - DOS on the bill is within 6 mos. of the combined application date, *and* it is for treatment of the original diagnosis (Dx)
  - DOS of the bill is beyond the 6 months *and* you are also scanning a treatment plan or additional request that covers the dates of service on the bill; Original/same Dx
  - Regardless of the DOS of the bill, it’s for services on a different/new incident/Dx *and* you are scanning a new combined app. sent to you from the provider *and* a BOCC approval and new medical records. (This is most likely a new county case, but not a new CAT case if within the 12 mos. CAT year)
Catastrophic Fund: Assignments

- After receiving notification from county (example of required format on following slide) to close a case, CAT will send county the assignments for signature.
- Assignments include the percentage due the CAT Fund from the total amount paid on all claims (see example on following slide).
- County retains copy of assignment for records.
- Scan signed assignments in SCI (See Sample Assignment Form).
Catastrophic Fund: Assignments

- Example: CAT fund payment - $15,000
  County payment - $11,000
  TOTAL $26,000

- Divide $15,000 By $26,000 = 58%
  CAT will receive 58% of all reimbursements collected by the County for that claim
Catastrophic Fund: Assignments

Submit cases to close in this format in Excel

<table>
<thead>
<tr>
<th>CAT Number</th>
<th>Last name, First</th>
<th>Anniversary Date</th>
<th>Total paid by county</th>
<th>Total paid by CAT</th>
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Catastrophic Fund: Reimbursements

- County reimbursement
  - County is required to reimburse CAT from payments received from the client in the percentage amount shown on the assignment.
  - County is not required to begin making payments until an assignment on the case is received from the CAT.
  - Provide a breakdown with the check to CAT, include CAT number and amount sent for each person.

- Provider reimbursement
  - When reimbursed by a provider (Medicaid, misc. refunds), reconcile precisely, per the amount paid. The % is not used to determine how much goes to CAT.
Catastrophic Fund: Policies

The CAT Board has adopted the following 5 policies:

- Medical Review Policy
  - All cases where billed charges exceed $75,000 shall have a medical review
  - CAT Cases or individual bills under $75,000
  - CAT will reimburse 50% of the cost of the review

- Use of CAT Board Legal Counsel
  - All requests for assistance or legal matters concerning indigency and the CAT program must be funneled through the program office.
Catastrophic Fund: Policies

Settlements

- For cases exceeding $11,000 the CAT program shall be clearly named in any lien filed and in any reimbursement agreements with any party.
- When a county negotiates the settlement of a case that includes CAT payments; and the amount being considered is a reduction of 25% or more of the account balance, such county must notify/email the CAT program office and provide the following:
  - Copy of recommended settlement amounts
  - Explanation and reasoning for settlement
  - Payment history of applicant
Catastrophic Fund: Policies

CAT Case Submission Policy and Procedures

- Requires all documents transmitted through a secure website;
- CAT program office notifies counties of case disposition in writing after each board meeting;
- Procedures in “CAT Case Determination and Processing Procedures” must be followed.
Catastrophic Fund: Policies

Alternative Coverage Policy

Processing and Submission Procedures

- Person must be deemed indigent
- County will scan similar documentation such as: lien and repayment by applicant; BOCC determination that person is indeed indigent; provide documentation showing estimated billed charges, estimated interim rate, cost of insurance premium, length of time approved for insurance,
- If approved for 6 months, then a medical review would need to be conducted a month prior to the expiration of the insurance unless one was done initially and recommended PCIP
- CAT would share the costs of the premiums
Collections By Hospitals and Providers

- Payment by an obligated county or board shall be considered payment in full and restrict billing an applicant or obligated person for such services. §31-3509(1)

- Once provider is notified another resource is available, provider must submit or resubmit bill to resource within 30 days notification §31-3509(2)

- Such resources include: third party insurance, Medicaid, Medicare, supplemental security income, crime victims compensation, workers compensation, other insurance, other third party sources or section 1011 funds.
Collections By Hospitals and Providers

- If provider receives payment from another source after county and/or CAT pays, such providers shall reimburse the county and/or CAT within 60 days. §31-3509(2)

- Any amount overpaid shall be an indebtedness to the hospital or provider due and owing. §31-3509(3)
Collections By Hospitals and Providers

Example:

- Doglife county paid $6,800 to RST Facility on behalf of Sarah Sue. Sarah Sue was later determined to be eligible for Medicaid for the approved dates of service. Doglife county has repeatedly made attempts to recoup the payment, to no avail. Doglife County has now approved Daisy Duke who is a new applicant for $6000 to RST Facility. Doglife County notifies RST Facility that no payment will be forth coming and RST still owes the county an additional $800 on the next claim. Bookkeeping nightmare, but it usually only takes once and the providers are willing to reimburse.

- Note: *This doesn’t work if it’s a CAT payment*
Non-Medical Indigency

The following slides provide information about the non-medical processes, timeframes, investigation and Board of County Commissioners determination processes. Included in these slides are the types of assistance available under Chapter 34, Title 31, such as: assistance for prescriptions, rent, utilities, burial and cremation.
Non-Medical Indigency

- **Powers and Duties of Board of County Commissioners §31-3401**
  - Provide temporary assistance when no alternative exists
  - Not to be provided on a continuous basis
  - Adopt Resolutions
    - Promulgate policies and procedures
    - Negotiate payments to providers
    - Contract for nonmedical services (§31-3402)

- **Definitions §31-3403(1) – (18)**
  - Utilized for nonmedical applications and processes
  - Separate from definitions in Chapter 35, title 31
Non-Medical Indigency

Definitions continued:

- “Adult household member” means any individual eighteen (18) years of age and over who resides in the household. §31-3403(1)
- “Applicant” means the individual and all others in the household who are requesting nonmedical assistance, and who submits a county application. §31-3403(3)
- “Assets” means property rights including, but not limited to, personal, real, tangible and intangible property. §31-3403(4)
- “Board” means a board of county commissioners. §31-3403(6)
Non-Medical Indigency

- Definitions continued:
  - I.C. §31-3403(7) “Clerk” means the clerk of a board of county commissioners or his designee. §31-3403(7)
  - “Emergency” means any circumstance demanding immediate action. §31-3403(8)
  - “Household” means a collective body of persons consisting of spouses or parents and their children who reside in the same residence; or all other persons who by choice or necessity are mutually dependent upon each other for basic necessities and who reside in the same residence. §31-3403(9)
Non-Medical Indigency

- Definitions continued:
  - “Indigent” means any applicant who does not have resources available from whatever source which shall be sufficient to enable the applicant to provide nonmedical assistance or a portion thereof. §31-3403(10)
  - “Investigation” means a detailed examination of the application and information required from the applicant and others to verify eligibility. §31-3403(12)
  - “Nonmedical assistance” means reasonable costs for assistance which includes food and shelter and other such necessary services determined by the board by resolution. §31-3403(13)
Non-Medical Indigency

Definitions continued:

- “Repayment” means the authority of the board of county commissioners to require indigent person(s) to repay the county for assistance when investigation of their application determines their ability to do so. §31-3403(16)

- “Resident” means a person with a home, house, place of abode, place of habitation, dwelling or place where one actually lived for a consecutive period of thirty (30) days or more prior to the date of application. §31-3403(17)

- “Resource” means assets, whether tangible or intangible, real or personal, liquid, or nonliquid, including, but not limited to, gifts, bequest, grants, all forms of public or private assistance §31-3403(18). Exemptions are allowed under §11-605 (1)-(3).
Non-Medical Indigency

- **Application §31-3404**
  - Must be on a form provided by the county
  - Shall be provided to any individual requesting county assistance
  - Must be filed with the clerk of the BOCC
  - Shall be signed by the applicant, or his authorized representative
  - Interview is required within 10 working days of the application
  - Must contain all household resources
  - Evidence of need shall be supplied by the applicant or authorized representative
Non-Medical Indigency

Application continued:

- Failure by the applicant to interview and supply supporting documentation shall result in a denial.

- Applicant and all household members who are not employed and capable of working must be registered with the department of employment.
  - The applicant and all other household members may be required to submit a medical statement certifying an inability to work.

- Proof of job search must be provided by applicant.

- Individuals who voluntarily leave the workforce may be denied.
Non-Medical Indigency

- **Duration of Nonmedical Assistance: §31-3405**
  - 1 month assistance in any 12 month period.
  - Assistance in any Idaho county applies to the 1 month benefit period.
  - The board may authorize by resolution an extension of the 1 month restriction. *(See Sample Resolution)*
  - By stating that the county is not obligated to more than one (1) month of nonmedical assistance, then obligates the county to at least one month.
Non-Medical Indigency

Investigation of Application §31-3406

- It is the duty of the clerk to investigate.
- The clerk shall file a statement of findings with the board.
- As determined by the board, the clerk may authorize the expenditures of sums as may be necessary to provide for immediate necessities.

Obligated County §31-3407

- The county where the applicant currently maintains a residence at the time of application.
  - Nonmedical assistance only requires that a residence be a consecutive period of 30 days or more prior to the date of application.
Non-Medical Indigency

- **Eligibility §31-3408**
  - Shall be based upon:
    - County Residency
    - Completion of application and interview
    - Failure to comply shall result in a denial
  - Counties are not obligated to provide assistance in the event the applicant has exhausted lifetime limits or is in noncompliance with their personal responsibility contract as defined by the Department of Health and Welfare.
Non-Medical Indigency

- Application of State and Federal Programs §31-3409
  - The Board by resolution may extend benefits, but the benefits must not be duplicated or available to the recipient from any other resource.
  - Applicant must apply for all other non medical assistance and/or programs.
  - In the event the applicant is denied other assistance, applicant must appeal and follow through to the final administrative level.
Non-Medical Indigency

- Decision by County §31-3410
  - Board shall give written notice:
    - Within 15 working days of the interview.
    - In an emergency the clerk or his designee shall make an immediate decision.
    - Decision by the Board is final if timely appeal is not filed.
Non-Medical Indigency

**Notice of Appeal §31-3411**

- Appeal shall be filed with the clerk of the board
- Must be in writing and filed within 30 days of the date of the board’s denial
- Board shall hold a hearing
- If board denies applicants appeal, applicant is entitled to file compliant with district court within 30 days of the date of the final written decision by the board.
- Proceedings conducted in same manner as A.P.A., Chapter 52, Title 67, I.C.
Non-Medical Indigency

- **Indigent Burial** §31-3412
  - Board shall provide for burial/cremation of any deceased indigent person.
  - Board must establish a set rate with funeral home.
  - Coroner, mortician or other responsible parties may make application in the event next of kin or other resources cannot be established;
  - Application must be made prior to services being rendered.
  - County free from liability for burial/cremation.
Non-Medical Indigency

- **Approved Claims §31-3413**
  - No claim shall be paid until eligibility has been established.
  - County is not obligated to pay for services received by the applicant prior to date of application.
  - County is not obligated to make payments to relatives.

- **Repayment by Recipient §31-3414**
  - Accepting county assistance obligates applicant to repay county.
  - County determines the repayment amount which is to be paid over a reasonable period of time.
  - Board may provide for work repayment.
Non-Medical Indigency

- **Divestiture §31-3415**
  - Applicants who divest assets or resources within 3 months prior to filing county application shall be denied.

- **Violations and Penalties §31-3416**
  - Persons who withhold information, or give false or incomplete information in order to obtain county assistance shall be guilty of a misdemeanor.

- **Confidentiality §31-3418**
  - All proceedings/records relating to indigency shall be exempt from disclosure pursuant to Chapter 3, Title 9, I.C.
Mental Health

Specify Process & timelines (admission thru commitment)

Is there a specific number of days counties pay for an involuntary admission or a protective custody hold?
Mental Health

WORK IN PROGRESS
Mental Health
Jail Medical

How are Jail Inmates Handled?

Is county responsible for jail medical expenses?
§20-605 says that any inmate in need of medical treatment shall receive such treatment and it is the responsibility of the sheriff to pay for the costs, provided they are in their custody.

*(See CAT Jail Medical Memo)*

Also a county cannot release a inmate from their custody in order to receive medical treatment.

*St. Alphonsus vs. Killeen (1993)*
Jail Medical

- It is the expressed opinion of the each county’s Sheriff and County Commissioners as to which department’s budget gets to pay for health care for inmates in their custody.

- The CAT Board’s attorney has given opinion that the CAT Board will not pay the excess of $11,000 for those applicant’s who are in the custody of the County Sheriff.

- Does the Custodial County have responsibility to pay the medical bills? Yes

- Does the Inmate’s county of residence indigent department have responsibility to pay the medical bills? No as long as the inmate was in custody of the Sheriff and was not released solely for medical treatment.
Jail Medical

Example:
Gunslinger Joel was incarcerated in Holster County for burglary. After several days, he became incoherent and was talking in tongues. The Judge issued an order removing Joel from Holster County custody for medical treatment and putting him in the custody of Smith & Wesson hospital. The order further stated that Joel was to be remanded back to Holster County custody after his treatment. Gunslinger Joel had an aneurysm and expired during the hospital stay. Smith & Wesson filed a 3rd party combined application into Trigger County, as he had lived there 27 years. Trigger County denied the application as not the last resource; citing I.C. 20-605 and 31-3302. Trigger County and Smith & Wesson facility held a hearing. During which, the Judge testified that there was no other reason, except for medical treatment, which would have resulted in the inmate being released from custody.

Decision: Trigger(resident) County denied as inmate was in Holster County Jail and custody. Per 20-605, an order releasing custody cannot be entered for medical treatment. Per 31-3302, the expenses incurred
Jail Medical

WORK IN PROGRESS
Acronyms of Interest

- ADA: Americans with Disabilities Act
- AFDC: Aid to Families with Dependent Children
- BOCC: Board of County Commissioners
- CAT: Catastrophic Health Care Cost Program
- CAU: Combined Application Unit
- DOB: Date of Birth
- DOI: Department of Insurance
- DOL: Department of Labor
- FQHC: Federally Qualified Health Center
- HIPAA: Health Insurance Portability and Accountability Act
Acronyms of Interest

- IAC: Idaho Association of Counties
- ICN: Internal Control Number
- IDHW: Idaho Department of Health and Welfare
- PCIP: Pre-existing Condition Insurance Plan
- SCI: Security Connections, Inc.
- SS#: Social Security Number
- SSD: Social Security Disability
- SSI: Supplemental Security Income
- VA: Veterans Administration
- Voc Rehab: Vocational Rehabilitation
Definitions
Definitions
Q & A

Q: Can you mix a emergency application with a non-emergency application?
A:

Q: Are all applications received by IDHW denied?
A: No. Counties only receive notice and the applications that are denied by IDHW. If they approve then it becomes a Medicaid application and the county is no longer considered.

Q: Can an indigent make payments by credit card?
A:
Q & A

Q: Can and should a county release a lien for refinancing?
A:

Q: What happens to the county lien in a foreclosure?
A:

Q: Can one application handle multiple dates of service?
A: Counties do and have received applications with multiple dates of service but usually for one malady.

Q: What happens if a hospital bills for incorrect services or for services before they have been provided?
A:
Q: What should I do if I receive bills for services and have not received an application?
A:

Q: How long do I have to keep my files before destroying them?
A:

Q: Do counties provide dental care?
A:
Q & A

Q: How long do I hold an application in suspension?
A:

Q: Non Medical: If next of kin is established but neither the deceased or next of kin can pay for the services, who does the county determine as responsible and should county pay?
A:

Q:
A:
Q & A

Q: How long do I hold an application in suspension?
A:

Q:
A:

Q:
A:

Q:
A:
NOTES:

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