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| Registration for Eligibility of 3 rd Party Resources including Medicaid Pending and County Referrals Formulated: 7/25/05 | Reformatted: Revised: 1/04/07 |

Registration for Eligibility of 3rd Party Resources including Medicaid Pending and County Referrals

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| Purpose | To provide instruction in the registration of patients who are potentially eligible for Medicaid or any other 3 rd Party Resource |
| Audience | All Admitting registration entities |
| Policy | All staff are to follow the Eligibility procedure to assure that all potentially eligible patients are referred to the appropriate 3 rd Party Resource and procedures for registration process is followed. |

PROCEDURE:

MEDICAID PENDING ELIGIBILITY DETERMINATION

Listed below are the criteria to identify a potentially eligible Medicaid/Star eligible patient.

- **Any patient under the age of 18**
- **Any non-funded pregnant women**
- Any patient with biological minor children under the age of 18 in the household **and** whose income criteria meet the TANF income guidelines.
- Any patient given court appointed "parent" status with a minor child now living in the household.
- Any patient "legally" responsible for a biologically related minor child in the household **and** income criteria meet the TANF income guidelines.
- Any patient who is an undocumented alien with minor children in the household who are United States Citizens.
- Resident Aliens who legally entered the U.S. prior to August 22, 1996 may qualify for ongoing SSI or HHSC Programs.
- Resident Aliens who legally entered the U.S. on or after August 22, 1996 must meet specific criteria in order to qualify for cash benefit programs or ongoing Medicaid.
- Any patient who is an undocumented alien who do not meet the Resident Alien Criteria may qualify with an emergency medical condition **and** disabled for 12 months.

SSI PENDING ELIGIBILITY DETERMINATION

SUPPLEMENTAL SECURITY INCOME (SSI) PENDING

SSI Program is administered by the Social Security Administration. Patients eligible for SSI are also eligible for Medicaid coverage which includes children and adults. The eligibility criteria are Income, Resources, and Disability. There are three program categories which are listed below.

1. Blind (totally blind or have very poor eyesight) Corrected vision of 20/200 or less in better eye; field of vision less than 20 degrees.
2. Disabled (Physical or mental problem that keeps you from working and is expected to last at least one year or result in death. With children Social Security looks at how his/her disability affects everyday life)

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3. 65 years or older

If any of the below criteria applies to the patient and unearned income (i.e. Social Security or Unemployment Benefits) is no greater than \$523.00 for single or \$934.00 for a couple, also, if the income is earned (i.e. wages or salary from a job) and then the income amount is no greater than \$1326.00 for single or \$1948.00 for a couple then follow the procedures below for loading SSI pending. (These amounts update annually on January 1st of each year.) These have been updated with the amounts that are effective for January 1, 2007

Listed below are the criteria for identifying potential eligible SSI patients.

- Any patient who suffers from a physical or mental impairment that prevents them from doing any substantial work and the disability is expected to last at least twelve months or result in death.
- Any patient who verbally states that they have applied for SSI.
- Any patient whose account has SSI already loaded with "Y" verification flag
- Any patient who can provide documentation that they have applied for SSI and they have received a letter from the Social Security Office.
- Any patient who can provide documentation that they are in the appeals process for an SSI application that has been denied and they have received a letter from the Social Security Office.

WHEN and HOW TO LOAD THE PENDING INSURANCE PLANS

Prior to referring or loading the pending Medicaid or SSI insurance plans, check HDX, CEI, Florida Shared, TMHP, etc. to make sure the patient doesn't already have Medicaid or an application on file. Also be sure to ask patient if they have any other health insurance coverage. If a patient indicates that they have previously applied, but there is either NO RECORD or they received an INVALID DENIAL (such as 076, 094, etc., see list of invalid denial codes attached to this policy), the patient will need to re-apply for Medicaid. At any time a patient is referred to apply (or has applied) for Medicaid or SSI, the account needs to have the appropriate pending plan loaded to the account(s). The pending insurance plan is used as a flag by registration personnel and the Eligibility Programs area to track the pending status and follow up with patients to complete the application process.

PENDING MEDICAID /STAR OR ANY OTHER PENDING PLAN

If the patient fits the Medicaid Eligibility Criteria, then follow the procedure below for loading Medicaid/Star pending. Also use this process if patient has already applied for Medicaid and has a good application number on file with Medicaid.

- Load the third party code 3PEND OR other appropriate pending plan for Medicaid/Star. See help screen (next page) if assistance is needed to determine the appropriate pending insurance plan.
- The Financial Class will default to "P" (refer to the Financial Classification of "P" to "V" policy) and the appropriate payscale. If appropriate to make account a "V", then change the "P" to a "V".

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- Verification flag should be set to "Y" and enter "pending" in the policy number field. If the patient already has a valid application on file with Medicaid, place application number in the policy number field.
- 3PEND or appropriate pending plan should be prioritized as "1" unless they have other coverage.
- Any other coverage that applies to the specific case should be "Y" verified and prioritized as "1" and 3PEND prioritized as "2" except agency coverage (i.e. CIDC, KHP and County, etc..).
- Note in the comment screen of your findings. If current application, note comments with the Application Number and File Date. Use the current application number.
- The pending insurance plan **MUST BE** loaded to the account even if patient has been approved for Medicaid, but does not have the recipient number assigned yet.

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UTMB INSURANCE PLAN HELP SCREEN                                08/17/05 0927
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? AETNA
? BLUE CROSS
? CHIPS
? CIGNA
? HEALTH ADM SERVICES
? HHPO/PPO NEXT
? HUMANA
? PRUDENTIAL
? UNICARE
? UNITED HEALTHCARE
? OTHER MANAGED CARE PLANS
? NON CONTRACT COMMERCIAL
? WCI PLANS

? UTMB EMPLOYEE PLANS
? MAJOR EMPLOYERS
? TRICARE/ARMED FORCES/VA
? PRISONERS
? AGENCY PLANS
? COUNTY/HOSPITAL DISTRICTS
? BEHAVIORIAL HEALTH PLANS
? SPECIALTY PLANS

? MEDICAID INCLUDING MANAGED CARE PLANS
> MEDICAID OR CIDC PENDING PLANS
? MEDICARE INCLUDING REPLACEMENT PLANS
? MEDICARE SUPPLEMENT PLANS

***** OR YOU MAY KEY IN ONE OF THE FOLLOWING AND ENTER *****
                INVISION CODE: ____ SIGNATURE CODE: ____

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& ENTER TO CONTINUE

01PLAN01

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FYI: 3ALN = Emergency Medicaid - This is used for Undocumented Aliens who don't qualify for regular Medicaid . The undocumented alien must have an emergency condition in order to qualify for Emergency Medicaid. Emergency Medicaid is only certified for the Inpatient (100000.....) and Emergency (300000.....) accounts. It does not cover **outpatient** (20000.....) clinic charges.

- OB-Satellite (OBS) Clinics load emergency Medicaid with an "X" verification flag. This is to notify Admitting that this patient qualifies for emergency Medicaid coverage and a 3038 form needs to be completed and signed by the patient and the physician treating the patient.

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- OBS clinic will load the appropriate code (3ALN) to the outpatient account and enter "pending" in the policy number field.
- The "3ALN" should be "X" verified on the outpatient case (20000.....).

Listed below are procedures for the ER to follow regarding loading 3ALN Emergency Medicaid.

- The undocumented alien must have an emergency condition.
- A 3038 form needs to be completed. This form must be signed by the patient and physician who is treating the patient.
- The ER will load the appropriate code (3ALN) to the ER case and enter "pending" in the policy number field.
- The "3ALN" should be "Y" verified on the ER case
- The Financial Class will default to "P" and the appropriate payscale.
- Patient equals to guarantor
- Enter in the "comments" screen that a "3038 form was obtained and signed by patient and physician.
- Completed and signed 3038 should be forwarded to Eligibility Program Unit at Route 1076.

SSI PENDING

If the patient meets the SSI pending criteria, then follow the procedure below for loading SSI pending.

- Load the third party code 3SSI for SSI pending. The Financial Class will default to "P" (refer to the Financial Classification of "P" to "V" policy) and the appropriate payscale. If appropriate to make account a "V", then change the "P" to a "V".
- Verification flag should be set to "Y" and enter "pending" in the policy number field.
- SSI pending should be prioritized as "1" unless they have other coverage.
- Any other coverage that applies to the specific case should be "Y" verified and prioritized as "1" and SSI pending prioritized as "2" except any agency coverage (i.e. CIDC, KHP and County, etc..).
- Note in the comment screen of your findings.

HOW THE CLINIC STAFF HANDLE PENDING PATIENTS

A pending status patient is considered an unsponsored patient in the clinic. These patients must go through the DAMP process to access the clinics. The "P" patient is expected to pay full DAMP deposit amounts (> greater than 250% FPI deposits) **no matter what payscale is set on the account**. The "V" patient is allowed to pay the < Less than 250% deposit amount if the payscale is set to an Indigent status (Payscale S, J, 0 and sometimes 5).

If the patient is in the clinic for an appointment and the clinic staff finds that the patient now has active Medicaid coverage, then the clinic staff will load the correct Medicaid Insurance plan. Any Medicaid pending account which is expired, must be set up with a Financial Counseling appointment prior to their next clinic visit

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LOADING MEDICAID COVERAGE TO THE PATIENT'S ACCOUNT

When the patient receives active Medicaid coverage, the correct insurance plan needs to be loaded to the patient's account(s).

- If the patient has a Financial Class of "P", "V", "N", or "K" and the payscale of "S", "J", "O", or "5" do not change.
- Use the original effective date for Medicaid/Medicaid Managed Care of the first effective date without a break in coverage.
- For Medicaid TP30 program, use the earliest effective date and last termination date.
- TP55 and TP30 programs are Medicaid coverage if they open and closed dates.
- TP55 – MUST check HDX Invision for any TP55 coverage that doesn't have "S" (medically needy) for TP67 BCCCP Program. The correct insurance plan code for BCCCP is **3TX04**.
- Patients name and date of birth must match HHSC records, if they do NOT, complete UTMB Medicaid Patient Name Change/Correction form and forward to Eligibility Programs Unit at Route 1076. (see form which follows this procedure)
- Do not load TP14 with type of coverage "T" Primary home care service only (There will be no "Q" under the QMB column on a CEI inquiry.)
- TP14 with type of coverage "T" with a "Q" can be loaded and billed.
- Load the correct third party plan code for the Medicaid/Medicaid Managed care plan to ALL cases in Invision (unless the patient is currently inhouse) that fall within the effective date of coverage with the correct insurance priority and "Y" verify and effective date of coverage.
- Load Medicaid/Medicaid Managed Care to PIDX if there are no active cases in Invision.

For patients that are inhouse:

- Contact Inpatient Registration staff by phone or pager:

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| ○ (Medicaid) Managed Care/Commercial | X23607 | Pager 645-8551 |
| ○ Un-sponsored or 0 pay | X72596 | Pager 643-1666 |
| ○ Medicare/Medicaid | X70918 | Pager 942-6801 |

PROCESS FOR REMOVING THE P OR V

Each pending patient's account is followed by the Admitting's Eligibility Programs Unit, PBS Pending Area, and the vendors, MASH and NCO. These areas periodically check the status of a pending account and assist the patient in completing the application process.

In **most** cases, the Eligibility Programs area should be responsible for taking the "P" or "V" off of the account. The other registration areas should **carefully assess** an account before making a decision to remove pending from a patient's account.

There are only a couple of instances when it would be appropriate for the Financial Registration areas to remove for the pending plan and financial class.

1. If patient receives a valid Medicaid Denial only if it is **not a child or pregnant patient** with an 071 denial code (over income). Eligibility Unit would want pursue spenddown Medicaid for this population and it would require an 072 denial code (over resources).

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2. If patient was **recently** determined to have applied for SSI pending and has not completed ANY part of the application process, but through the course of the screening, the actual income information puts them over income for the program or you find they do not have an ongoing disability and will be returning to work soon. **See ****IMPORTANT NOTE, NEXT PAGE******

*******IMPORTANT NOTE for removing the pending status*******

If you do decide to remove the pending plan and change the financial class **or** are not sure if you should, please email the Sr. staff at Eligibility Programs (Jean Shepherd, Sonia Huerta, and Maria Betancourt) with the information on the patient's account.

EXPIRED MEDICAID/STAR COVERAGE

When a patient is no longer eligible for Medicaid/Star, that plan should have an "X" verification indicator and an expiration date. In addition, any time that a patient has previous Medicaid/Star coverage that has expired, it should be considered that the patient may need to re-apply and therefore the patient would be assisted in the application process (See page 1 for criteria for identifying potentially eligible Medicaid/Star patients). There have been some instances where it appears that Medicaid or Star has expired, so the patient was given a discount and their recertification for Medicaid or Star was not pursued. If the patient fits the criteria on page 1 then follow the procedures listed on page 1 for loading the appropriate pending plan.

REFERRING PATIENTS TO APPLY FOR COUNTY INDIGENT HEALTH PROGRAMS

This referral process is extremely important if the patient is not potentially eligible for Medicaid. Any SSI Pending patient should also be referred to their county program if they meet the following criteria. Some counties will cover the SSI pending status patients, but others will not.

A patient with an income of 21% FPI (or less) OR 100% or less if patient lives in a County Hospital District should be referred to the appropriate county health or hospital district office to apply for the County Indigent Health Program. All county programs use resource testing in their application process. You will need to ask the patient if they own any property other than their house or one car. If they do not own any **other** property, then they will need to be referred to apply. Be sure to inform patient to request application for the Indigent program specifically because some counties will only consider patients for their primary care program unless you specifically request application for the indigent program.

No outpatient, DSU, or inpatient account should ever be discounted without either a valid denial from the county plan or actual coverage for the indigent program (not primary care). The valid denial letter must be scanned and kept in the imaging system along with all the valid financial documents for receiving the discount. If outpatient or DSU accounts are involved, contact the County Affairs office to notify them that the patient now has active county coverage. The County Affairs office will get authorization for any future clinic or DSU visits and will load the appropriate county insurance plan once authorization is obtained. ****If the patient has received services within the last 90 days, there is a possibility that County Affairs could bill the county for prior services. If there is an inhouse inpatient account, notify the inpatient registration staff (see Loading Medicaid process) so that they may get appropriate authorization and load the county plan.**

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ER accounts will still complete the affidavit form and load the account with the discount if applicable, but will need to put a comment into the comment screen that patient was referred to their County Indigent Program for application.

QMB, SLMB OR QI-1

A patient may also be eligible for additional assistance through the Medicaid Aged and Disabled Program under the QMB, SLMB or QI-1. Follow these income and general guidelines when referring patient to apply for these programs. (These amounts update annually on April 1st of each year.)

2006 INCOME LIMITS/EFFECTIVE APRIL 1, 2006

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| QMB (Medical & Premium Costs) | Single | \$837 - \$20 exclusion = \$817 / \$4000 resource limit |
| | Couple | \$1120 - \$20 exclusion = \$1100 / \$6000 resource limit |

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| SLMB (Premium only) | Single | \$1000 - \$20 exclusion = \$980 / \$4000 resource limit |
| | Couple | \$1340 - \$20 exclusion = \$1320 / \$6000 resource limit |

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| QI – 1 (Premium only) | Single | \$1123 - \$20 exclusion = \$1103 / \$4000 resource limit |
| | Couple | \$1505 - \$20 exclusion = \$1485 / \$6000 resource limit |

For patients who reside on Galveston Island, Port Boliver, Crystal Beach, and Gilcrest refer to Susanne Lumpkin at (409) 772-9989. For patients who live on the Mainland, Galveston County, refer to the Texas City Office at (409) 948-1701. For other areas of residence, refer patients to their local HHSC Aged and Disabled Program in their area.

Refer patient to these programs if they qualify but you would not load any PENDING PLANS to the patient's account(s). When the patient obtains the coverage, you would load the Medicaid plan if appropriate.

FINANCIAL CLASSIFICATION OF “P” TO “V” *SEE SEPARATE PROCEDURE*

IDENTIFICATION OF ELIGIBLE PATIENTS FOR SECTION 1011 FEDERAL REIMBURSEMENT (UDA 1011) *SEE SEPARATE PROCEDURE AND FORM*