

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.
SUBGRANTEE GUIDELINES
Policy and Procedure

DOCUMENTATION OF THIRD PARTY ELIGIBILITY (SG-06)

EFFECTIVE DATE: November 17, 2006

PURPOSE:

To establish requirements for documentation of Third Party Payors (including Medicare and/or Medicaid) eligibility/ineligibility for all funding from the Resource Group.

DEFINITIONS:

Subgrantee is an agency that has entered into a grant agreement with the Resource Group to provide services.

POLICY:

Each Subgrantee that receives funding from The Resource Group must obtain and maintain documentation of Third Party Payors (including Medicare and/or Medicaid) for all applicable services. The Subgrantee should establish a procedure to obtain and maintain the acceptable forms for documentation of client eligibility/ineligibility for third party payment prior to utilization of The Resource Group's funded grants. The procedures must comply with the requirements outlined below. (NOTE: This applies to all funding administered by The Resource Group.)

PROCEDURE:

1. Upon receiving funding from The Resource Group, the Subgrantee must develop a screening procedure for all clients to obtain and maintain the documentation of Third Party Payors (including Medicare and/or Medicaid) eligibility/ineligibility for all applicable services that meet or exceed the requirements outlined in this policy. The screening process should include steps to:
 - a. Determine what employment-based medical insurances each client currently holds;
 - b. Determine what publically-funded medical insurance benefits (e.g. Medicaid) each client receives;
 - c. And, conduct a financial assessment to determine if the client is eligible for any publically-funded medical insurance benefit program.

2. The documentation of eligibility/ineligibility should always remain within the active client record. The documentation of eligibility/ineligibility should **never** be archived. Documentation of Third Party Payors should be documented where appropriate in the data collection system (ARIES/CPCDMS). Eligibility/ineligibility should be recertified annually.
3. Eligibility/ineligibility must be recertified at least annually or when the client's circumstances change.
4. The following service categories must provide verification of client ineligibility for Medicaid/ Medicare or third party coverage (to assure that Ryan White is payor of last resort) for the dates that were provided:

Medicaid/Medicare Reimbursable Service Categories

Outpatient Ambulatory Medical Care	Oral Health Care
Home Health Care	Substance Abuse Treatment
Mental Health Services	Vision Services
Psychiatry	Transportation

5. Acceptable documentation to verify third party payor eligibility status:
 - a. Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare eligibility status)
 - b. Medicaid/Medicare rejection letter covering the dates of service
 - c. Signed note in patient record showing date and time of call to Medicaid/Medicare (must be done monthly)
 - d. Medifax slips or other automated system (must be done at least monthly)
6. The following Subgrantee systems will be reviewed:
 - a. Policy for the Third Party Payor Process
 - b. Training of staff on Third Party Payor issues.
 - c. Priority list of all publically funded medical insurance benefits held within the caseload or that individual clients are potentially eligible for, plus all employment-based medical insurances held by clients with the agency caseload.
 - d. Enrollment process with clients who are potentially eligible for Medicaid and/or other publically-funded health insurance benefit program(s).
 - e. Establishment of and compliance with Subgrantee system for charging, collecting, and tracking client monies, including insurance co-payments and client contributions to their own medical care whether on a sliding scale of flat fee basis.
 - f. For clinic-based Subgrantees, application for the ability to bill Medicaid, Medicare and Employer-Based Insurance companies, etc.

- g. For free-standing case management facilities, pursuit of billing for available third party payors for services provided with contracted physicians and other Medicaid-eligible services.
 - h. Subgrantee financial systems to track services, billing and payments from third party payors.
 - i. Application for waivers for low priority third party payors.
 - j. Billing to third party payors
 - k. Charges and collection of client contributions to medical care.
7. Services rendered under The Resource Group's funding for days on which a client was eligible for Medicaid, Medicare, or another third party payer will be recouped.
 8. Subgrantees must make a reasonable attempt to collect monies, however, services must be provided without regard to ability of the client to pay. Monies owed but not received from the client are not considered uncollected debt. Subgrantees should not track these amounts. Any monies received are considered program income for that month, regardless of when the services were provided.
 9. A Subgrantee may establish thresholds of documentation that exceed these minimum requirements. However, no Subgrantee may establish thresholds of documentation that fail to meet these minimum requirements.
 10. Compliance with this policy will be monitored as part of each Subgrantee's annual quality compliance review.