Texas Tech Physicians
of EL PASO

POLICY AND PROCEDURE

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Approved by:

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Un-reimbursed Costs of Medical Care Policy and Procedures

PURPOSE:

The purpose of this policy is to establish uniform guidelines across all clinics of Texas Tech Physicians-El Paso Paul L Foster School of Medicine in providing financial assistance for the provision of professional medical care.

DEFINITIONS:

Bad Debt- Uncollectible billed charges for services rendered to patients who do not qualify under the definition of financially or medically indigent and/or un-reimbursed costs from coverage limitations in government programs. Unsponsored cost of care does not include bad debts.

Contractual Adjustments- Discounts made due to the legal agreements with third party payors.

Financially or Medically Indigent- Any person with annual household income at or below the percentage of the Federal Poverty Income Levels of 100% (financial) and 200% (medical) will be qualified for a discount. The financially indigent status derives from income information obtained from the patient through financial screening.

Discount Amounts - There are two levels of discount: 70% and 40%. For Outpatient Evaluation and Management services, the minimum payment shall be $60.00 payable at the time of service. All other services (excluding various specialty programs) will bill at 100% Medicare. The MPIP Policy committee may recommend to the Dean changes in the minimum payment amount for specific services or product.

Un-reimbursed Costs of Government Programs Coverage Limitations- The amount of services to patients eligible for state government programs that exceed specified coverage limits and no additional coverage is available.

POLICY SUMMARY

This policy establishes requirements for the determination of eligibility for financially indigent status and a person's qualification for a financial class discount.

Indigent patients must meet the following criteria:

FINANCIALLY OR MEDICALLY INDIGENT:

1. Proof of residency in the local and surrounding counties that make up the clinical market base; and in the state of Texas.

2. Household size and composition are an adult couple, and any children under the age of 19 years old. Common-law marriages may be eligible.

3. All patients with annual household gross incomes between 100% and 200% of the Federal Poverty Income Level (See Attachment A).Gross income is established by the inclusion and exclusion of certain types of income as outlined in the policy.

4. Covered services shall include hospital and clinical outpatient and inpatient professional fees and/or professional interpretation components of radiology.

5. Failure to provide all required information will be cause for denial.

6. The period of coverage for a financially indigent patient is 12 months. An indigent patient with publicly sponsored health insurance with non-covered services will receive the discount. The MPIP Managing Director, on the Retroactive Discount Form, determines retroactive eligibility for a financially indigent patient.

7. All patient discount applicants will be subject to credit review through (TransUnion) for verification of information.

PROGRAM ADMINISTRATION

MPIP Central Registration will manage the TTUHSC-El Paso Paul L Foster School of Medicine Indigent Health Care Financial Assistance program.

PROCEDURES:

The following requirements are applicable for financially indigent eligibility, unless noted otherwise.

1. **Residency:** Applicants must be a bona fide resident of the State of Texas and must provide (2) proofs of residency.

2. **Valid Identification:** A valid form of identification such as a driver's license or other form of government issued identification.

3. **Household Size/Composition:** The number of household members must be determined to identify appropriate income guidelines. The term "household" is a single adult or adult couple with dependent children under the age of 19 years of age.

4. **Income Eligibility Guidelines:** Income must not exceed TTUHSC guidelines. Gross income will determine eligibility. Proof of income is required. All applicant information will be subject to verification through (TransUnion) credit reporting agency.

5. **Covered Service**

    a. Outpatient/Inpatient professional fees not covered by Hospital District;
    b. Professional component for radiology both inpatient and outpatient;
    c. All laboratory interpretation services billed for by the medical school;
    d. Any and all other professional fees as recommended by the MPIP Policy Committee and approved by the Dean

6. **Failure to Cooperate**: The applicant is responsible for providing all required information that is necessary to determine eligibility. Failure to provide this information may be cause for denial.

7. **Appeal for Denial**: Any applicant denied benefits under the TTUHSC El Paso Paul L Foster School of Medicine clinic discount program may appeal the decision in writing to the Managing Director of MPIP Business Operations MDBO. The MDBO has authorization to review an appeal and reverse a denial for any period up to 12 months.

8. **Program Application:** Applicant approval extends for no more than a 12-month period. Retroactive eligibility may extend to include all unpaid charges within the last spell of illness.

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Medical Practice Income Plan
Office of the Managing Director

Indigent and Self Pay Fee Schedule Pricing Update

Indigent Care FSC 297:

The new financial class discount pricing policy replaces the sliding scale discount policy previously used. Although patients qualify by Central Registration in the usual manner and their accounts use FSC 15 and 17, FSC 297 applies at the invoice level. Using FSC 297 triggers the Medicare rate for all charges on the invoice except for E&M codes which flat rate at $60. Patients are required to pay $60 at the time of clinical outpatient services and may be required to pay for additional services when leaving the visit. Pre-notification of discount patients and lead-time prior to implementation is advisable. Patients are required to pay the full Medicare rate for all services without additional discounts.

Departments should send all indigent, uninsured patients to UMC for inpatient and hospital outpatient services. Departments may send uninsured self-pay patients who wish to pay full price for services to another hospital for higher than Medicare reimbursement (see below) when the self-pay policy becomes effective. Full current price is applicable to those self-pay patients not seen at UMC until the self-pay policy becomes effective.

Any uninsured patient at UMC falls under FSCs 375 and 376 for hospital district reimbursement for the departments of Family Medicine, Internal Medicine, Orthopaedic Surgery, OB/Gyn, Neurology, Pediatrics and General Surgery. All other departments use FSC 297 for inpatients and hospital outpatients that have a registration FSC of 15 or 17.

Some exceptions apply to specialty services with grants, contracts or policies approved by the Dean. All exceptions require additional review for technical applicability and appropriate reimbursement. Some specialty department may charge a deposit for clinical outpatient services. Deposits will be applied to the services of the department and if a deposit balance occurs, the remainder applies to all other outstanding balances first prior to consideration of refund.

The indigent care pricing was effective October 1, 2011. All departments should have implemented or be in the process of implementation through December 31, 2011.

Self-Pay FSC 451:

The new self-pay pricing policy ***is effective only for Family Medicine and Internal Medicine at this time.***

All procedures outlined above for FSC 297 operate in the same manner for FSC 451; however the E&M pricing is $80 for established patients and $100 for new patients (see attached grid). Using FSC 451 triggers the 145% of Medicare rate for all charges on the invoice except for E&M codes.

Departments should send all indigent, uninsured patients to UMC for inpatient and hospital outpatient services. Departments may send uninsured self-pay patients who wish to pay full price for services to another hospital for higher than Medicare reimbursement (see below) when the self-pay policy becomes effective. Full current price is applicable to those self-pay patients not seen at UMC until the self-pay policy becomes effective.

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Medical Practice Income Plan
Office of the Managing Director

MSA Contract Claims Update

Hospital District MSA Contract:

The 24 month HD MSA Contract for patients who are uninsured and treated at UMC as an inpatient, hospital outpatient and Emergency Room, went into effect October 1, 2011. The billing departments under this new contract are Internal Medicine, Family Medicine, OB/Gyn, Orthopaedic Surgery (non-trauma), General Surgery (non-trauma) and Neurology.

Pediatrics MSA billing methodology and prospective reimbursement moved to the Childrens Hospital MSA and remains the same as the old MSA contract.

The RVU billing and payment specifics are as follows:

HD Payment Amount: Medicare

Patient Co-Payment Amount: 0.00 (there will be no balance billing). Since there is no balance billing, any uninsured patient should not have a deposit. If the patient later qualifies for Medicaid, they will still not have a payment.

HD FSCs:

- 375 if patient qualifies for financial class discount (Hospital District Indigent Care Uninsured)
- 376 if patient does not qualify for financial class discount and is uninsured (self pay)

Eligible Providers: All (There are no excluded providers under the new contract)

Eligible Claims:

- Claims ***billed*** in July 2011 paid November 2011.
- Claims ***billed*** in August 2011 paid December 2011 and so on…

Claims Reconciliation: This is a multi-step process as follows:

1. Since claims from July 2011 through October 2011 were paid prospectively and adjusted according to the previous contract, these claims will have to be readjusted without patient balances when paid claim by claim in subsequent months;
2. All claims billed beginning November 1st will have an automatic full balance adjustment to zero (pay code 104) until paid in subsequent months;
3. When claims are paid in subsequent months, adjustments will be reversed and payments posted. If insurance is found on any accounts, adjustments will be reversed and FSCs changed for billing;
4. Medicaid pending patients will be handled in the same way but FSC 315 will be changed to another FSC to remove patient billing;
5. Claims paid under the new contract will be reconciled with claims paid prospectively under the previous MSA contract and will reduce the final 2011 balance due to TT;
6. Deposits made by uninsured patients for elective surgeries or procedures at UMC will be applied to non-hospital district invoices first by all departments prior to consideration for refund.

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