

Clarifications and Additional Instructions for ICTF Onsite Reviews

Hospital services

2003 HFS Instructions, page 5: Hospital services are defined as the types of services provided under the auspices of the hospital's license and recognized by the Medicaid program as inpatient services, certain outpatient services provided within the hospital facility that could be billed to the hospital's provider number if provided to a Medicaid eligible patient, or ambulance services. Services that should not be included in this category are those provided by:

- Hospital based nursing homes and any swing beds within a hospital facility;
- Hospital based physicians;
- Outpatient pharmacies;
- Rural health clinics; and
- Home health agencies.

Issue: Pharmacy – If the service relates to pharmaceutical supplies provided during the course of a patient's inpatient or outpatient treatment, the service is considered to be a hospital service (example – medication provided for breathing treatment of a patient during a visit to an outpatient asthma clinic.) If the service is the type of service that would be billed as a Medicaid pharmacy claim if the patient was Medicaid eligible, the service is not considered to be a hospital service (examples – a physician writes a prescription during an outpatient visit for a 30 day supply of medication and the patient has the script filled at the hospital pharmacy.) A hospital's decision not to bill for pharmacy services would not automatically cause such services to be classified as hospital services; if such services could be billed in the Medicaid pharmacy program, if the patient had been Medicaid eligible, the services should be classified as pharmacy and not as hospital services.

Issue: Hospital based physician costs – even if physicians are hospital employees, physician services are not considered to be a hospital service. Report instructions state that physician services should be excluded for the Hospital Financial Survey. In a similar manner as for pharmacy services, a hospital's decision not to bill would not automatically cause such services to be classified as hospital services; if such services could be billed in the Medicaid physician program, if the patient had been Medicaid eligible, the services should not be classified as hospital services. If provided as a hospital outpatient service, facility fees for the non-physician portion of care provided to a patient may be classified as hospital services. Also, if a physician is providing administrative services only for a hospital, such costs may be considered as attributable hospital services.

DCH Clarification: For both prior and upcoming onsite reviews, the Department of Audits should inquire as to whether a hospital has properly classified pharmacy and physician services.

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Cash basis Medicaid receipts

2003 HFS Instructions, page 5: Cash Receipts should include all payments for the types of services and categories of patients included in the Charges section, from the appropriate payer source, for transactions recorded during the reporting period (regardless of whether the service was actually provided or billed within the reporting period). For the Georgia Medicaid program, do not include ICTF or UPL receipts. For Other State Medicaid programs, any DSH payments received during the report period should be included. Cash receipts should include any cost report settlements received by the hospital during the report period.

Issue: All hospital Medicaid cash transactions should be reported, including outpatient cost settlements (whether a payment to the hospital or a payment/recoupment to the Department) and ACS advance payments during 2003. Advance payments were disbursed and recouped at a payee level, so ACS advance payment transactions may be inclusive of hospital services and other types of providers with a common payee identification number. DCH can provide source documentation to identify the amount of any outstanding balance as of the end of a hospital's 2003 reporting period as well as data showing the portion of the outstanding balance that may be attributable to the hospital.

DCH Clarification: For both prior and upcoming onsite reviews, the Department of Audits should inquire as to whether a hospital has included advance payment transactions and outpatient cost settlement transactions in the cash basis Medicaid receipts. If a hospital did not include advance payment transactions, the Department of Audits should rely on the documentation provided by the Department to determine the amount that should be added to the hospital's reported amount of cash receipts. If a hospital did not include outpatient cost settlement transactions, the Department of Audits should rely on the documentation provided by the Department to determine the amount that should be added to or subtracted from the hospital's reported amount of cash receipts.

Service date vs. posting date

2003 HFS Instructions, page 5: Charges should include charges, in the appropriate payer source, for all services provided during the report period (regardless of whether payment for such services was received during the report period). The service dates should fall within the date range of the reporting period.

Issue: When providing detailed data, system limitations may prevent a hospital from providing charges by date of service. (example – charges for inpatient services may be available by date of discharge or date of admission rather than by date within an inpatient stay)

DCH Clarification: For an annual reporting period, the only differences between service date and posting date charge information can be expected for date ranges that span the beginning date or the ending date of the reporting period. If data is compiled on a consistent basis for both the beginning and ending dates as well as for reporting for prior and subsequent report period, no material differences would be expected and the use of a basis other than service date is acceptable. In cases when detailed data must be generated for the onsite review and inpatient data can only be provided based on date of admission or discharge, date of discharge data should be requested.

Uninsured

2003 HFS Instructions, page 6: Uninsured patients are those who have no health insurance, third party payments that would apply to the service for which the individual sought treatment. Patients with insurance coverage that provide limited benefits which are payable only to the patient may be classified as uninsured. **NOTE** - After correction of an editing error, the first sentence of the definition should read as follows: “Uninsured patients are those who have no health insurance **OR SOURCE OF** third party payments that would apply to the service for which the individual sought treatment.”

Issue: The following are example applications of the definition:

- Patient has insurance coverage and benefit limit is reached during an inpatient stay – insured
- Patient has insurance coverage and benefit limit is reached prior to an inpatient stay – Uninsured
- Patient has insurance coverage but a portion of the services during an admission are not covered by the payer – insured
- Patient has insurance coverage but no portion of the services during an admission are covered by the payer – Uninsured
- Patient has insurance coverage but hospital fails to bill claim properly – insured
- Patient has insurance coverage, hospital appears to have billed claim properly, and hospital has followed up with insurance company to confirm that proper billing information was received, but insurance company refuses to make any payment – Uninsured (note – a claim’s classification as uninsured should only be acceptable if there has been a period of at least 60 days since the hospital confirmed that proper billing information was received; the 60 day time period should be extended, if needed, if the hospital has any backlog in posting cash receipts to patient accounts.) If a claim has been billed to insurance and no payment yet received, in the absence of any other information, the service should be classified as insured.)

DCH Clarification: For prior onsite reviews, the Department of Audits should review work papers to determine if the example applications are consistent with

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work completed or if revisions to prior report findings may be needed. For upcoming onsite reviews, the Department of Audits should review classification of charges in accordance with the example applications.

Other issues from ICTF advisory committee comments

Issue: Medicaid charges - Medicaid classification is defined as follows: “This category includes those patients for whom a hospital expects or receives a payment based on the patient’s eligibility for ... a Medicaid program.” Possibly dependent on the capabilities of a hospital’s information system, a hospital may elect to classify Medicaid patients as those for whom Medicaid is the primary payer. It is permissible for a hospital to also include charges for patients for which Medicaid is a secondary payer; should a hospital do so, it should:

- Include only the portion of charges billed to Medicaid, with Medicaid cash receipts to include amounts received for claims for which Medicaid is a secondary payer) or
- Include the full amount of charges for such claims, with Medicaid cash receipts to include payments received from other payers for claims for which Medicaid is a secondary payer.

Issue: Charges and cash receipts for out of state patients – Such amounts are included in DSH limit calculations, with data reported in Part G-2A, lines 1 (charges) and 2 (cash receipts.)

Issue: Medicaid non-covered services and/or denied Medicaid claims – Non-covered services and/or denied claims for Medicaid eligible patients will be included in DSH limit calculations whether charges are classified and Medicaid or uninsured.

Issue: Cost to charge ratio based by Hospital Financial Survey or Medicaid cost report data – In order to avoid any additional delays in completing ICTF calculations, State Fiscal Year 2005 DSH limits and ICTF calculations will rely on cost to charge ratios based on Hospital Financial Survey data. A change to ratios based on Medicaid cost report data for current ICTF calculations would likely require an extended period to compile such data, for hospitals to verify their provider-specific information and for the review the reasonableness of the reported information. This issue can be reconsidered when ICTF policies are examined for State Fiscal Year 2006 calculations.