# Medicaid Applications

Due to the rise in uninsured, low income, pregnant, disabled and unemployed patients, it is increasingly important to qualify patients and assist them in completing Medicaid Applications so that their outstanding account(s) will be satisfied. Our Eligibility Services Unit focuses on helping self-pay patients through the often difficult and confusing process of applying for Medicaid in order to satisfy their obligation to the medical provider. Our unique 'one-on-one' approach treats each patient with dignity and compassion. Because of the time limitation for submission, it is important that cases be sorted first by the date of expiration to ensure timely submission. Understanding the need for documentation in order to substantiate the coverage, every case is treated with a sense of urgency. Since most patients are hesitant to send documents through the mail, we send our Medicaid educated Field Representative to the patient, if necessary, to obtain all of the documents for submission to Medicaid. We let the patients know that we are there to not only perform a service for the Hospital but for them as well. This gives them a comfort level, allowing them to trust and provide us everything that is needed to assist them.

The Medicaid Manager, prior to submission to the hospital, reviews each application for accuracy. This process greatly increases the percentage of approvals received by Medicaid.

In the event an application for coverage is denied by Medicaid, our Operations Manager will obtain consent from the patient to represent him/her at a fair hearing. Our Medicaid Operations Manager has 15 years experience and 100% success rate for reversing these denials.

Upon received approval from Medicaid, each case is reviewed for day outliers and cost outliers. This ensures that once payment is made to the hospital, it is paid in full.

In the event that we uncover Health Insurance information from the patient, coverage will be verified and the claim will be submitted to the carrier. Due to the pre-authorization rules, the Insurance Carrier will most likely deny the claim. Our office will submit an appeal on behalf of the Facility. In order to submit an appeal, the only additional information that we would require is the medical record, which we will request and come to the Facility and copy.

**Medicaid Application process**

1. Locating the patient with information given by client or with skip tracing techniques:

   All collection tools will be utilized in the location of all patients with potential Medicaid eligibility. Skip tracing software will continuously be a tool along with techniques producing necessary information. A three letter dunning series will be sent to the patient within 24 hours of receiving the work from the Facility.

2. Medicaid eligibility interview:

   All patients located will be interviewed for Medicaid eligibility with the utmost detail. All questions on the Medicaid application will be asked and a determination will be made through a budget and analysis process.

3. The Medicaid application:

   Once the patient is deemed Medicaid eligible, document gathering to complete a Medicaid application will commence. According to the budget and analysis we will determine what Medicaid category the patient qualifies. This will allow us to know what documents are mandatory for the Medicaid application.

4. The Department of Social Services (D.S.S.) face to face.

   An appointment with the Department of Social Services will be made on behalf of the patient to officially enter a Medicaid application within 3 months of the date of service whether contact with the patient was made or not. This allows us the time necessary to have a valid application at dss if the patient is located at a later date. Constant communication will be maintained with the D.S.S. caseworker in order to provide a seamless application process.

5. The Medicaid billing process

   Once eligibility is approved our billing process will commence. The client identification number (CIN) will be scanned for correct eligibility and you will be notified through our monthly status reports that this process has begun. Once the CIN number has been

verified, the account will be run against the N.Y.S. Medicaid D.R.G. Grouper to verify if the patient hospital stay qualifies for a day or cost outlier. The case will then be billed to Medicaid for reimbursement.

Our Company utilizes the largest hospital software billing system for all of our electronic claims submissions. The software is fully HIPAA compliant and updated on a daily basis with additional front-end edits required by Medicaid and all Insurance companies for clean claim submissions. Reports are generated daily, not only confirming the receipt of claims and providing proof of timely submission but notifying us of any errors as well.