

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

Integrated Service Delivery - Candy Shively, Deputy Secretary (785) 296-3271

Economic and Employment Support - Sandra Hazlett, Director (785) 296-3349

MEMORANDUM

To: EES Chiefs
Date: December 19, 2000
From: Jeanine Schieferecke *J. Schieferecke*
Terry Davis *T. Davis*
RE: Implementation of SOBRA
Eligibility Processes

The purpose of this memo is to provide instructions for implementation of procedural changes in the establishment of an emergency for purposes of determining SOBRA eligibility. SOBRA provides coverage of emergency services for persons otherwise eligible for Medicaid except that they do not meet the citizenship/alienage criteria. The procedures outlined in this memo are applicable for any MS-2156 initiated on or after January 1, 2001. The Kansas Medical Services Manual (KMSM) will be updated with this information at the next scheduled revision.

Background Information

In order to be Medicaid eligible under the SOBRA group, persons must have undergone treatment of an emergent nature as defined by federal statute. Prior to this change the process for determining if a condition met the definition of emergency was primarily dependent upon the provider of the service indicating if a condition would be categorized under a specific diagnosis code as an emergency condition. Since this process was adopted, several changes have occurred that have necessitated changing the process. Clarification has recently been issued from the Health Care Financing Administration (HCFA) regarding the definition of emergency treatment. Significant changes have taken place in the medical field that have resulted in numerous incorrect and inconsistent Medicaid billing procedures for SOBRA claims. The definition of emergency services was further expanded to allow emergency services to be performed in locations such as FQHC's, physician's offices and public health clinics. Previously, reimbursement was limited to services provided in an inpatient hospital setting only.

These changes have resulted in the need to begin a standardized review process of all alleged emergency services for persons applying under the SOBRA category. The review will be done by the Medicaid fiscal agent, Blue Cross and Blue Shield of Kansas (BC/BS), in consultation with the SOBRA Program Manager in Medical Policy. This will allow for uniform evaluation of all emergency situations and facilitate better understanding of the SOBRA eligibility process by providers of the service. If the evaluation indicates that an emergency did occur, appropriate billing information can be noted for later input into the MMIS, resulting in more accurate payment of Medicaid claims.

Eligibility Procedure:

The procedure outlined below shall be followed to determine if a condition meets the emergency criteria for SOBRA eligibility. The MS-2156, Medical Review of Emergency Services For Purposes of Establishing Eligibility shall continue to be used to document and communicate the decision regarding emergency services. This form has been revised to support the new process and a copy is attached. The form is to be reproduced locally.

1. Eligibility staff are responsible for initiating the MS-2156 for individuals who indicate an emergency service was provided by completing the information in Section I, Request For Information. This section should be completed as thoroughly as possible and both the Medicaid ID and Case Number fields are required. As this is the only method of identifying both the client and the worker, it is very important to write legibly. Although financial eligibility may not be determined at the point the form is initiated, it is appropriate to evaluate the applicants situation to determine if other eligibility criteria will be met. If the person would not otherwise be eligible (e.g. categorical or financial criteria are not met), it is not necessary to initiate the form. Staff should continue to initiate forms for persons who appear to meet criteria while awaiting verification, including verification of disability status from Disability and Determination Services. Once completed, the Specialist is responsible for forwarding the form to the appropriate provider of services. It is important to point out that the form shall be initiated ONLY by eligibility staff. Although representatives from other agencies may certainly assist in the process, the form will only be processed by BC/BS if it was originated by SRS eligibility staff.
2. Upon receiving the form, the provider is responsible for completing Section II, Verification Of Emergency Services. The provider will be required to include the dates of the emergency services on the MS-2156 and provide documentation of the applicant's medical condition through appropriate medical records. Medical documentation is required on all requests, even those for labor and delivery services. This information shall then be sent directly to the Medicaid fiscal agent, Blue Cross and Blue Shield of Kansas by the provider.

If the provider sends the MS-2156 back to the local SRS office in error, local staff shall send the form and all documentation to the SOBRA unit at BC/BS.

3. BC/BS staff will review the information submitted in conjunction with the SOBRA program manager from Medical Policy/Health Care Policy for an evaluation of the services provided and the persons medical condition. If additional information is needed to make a determination, BC/BS will send a standardized request form to the provider requesting this information. A copy of this notice is attached. Failure to respond to the notice within 15 working days shall result in a denial of the request. The MS-2156 will be updated with the final decision, signed by an Authorized Reviewer and returned to the Specialist who initiated the form. A form letter will also be sent to the provider regarding the approval/denial of the emergency condition. This notice only addresses the nature of the service and does not address eligibility and will also be sent to the Specialist along with the MS-2156. A copy of this form letter is included with this notice.

Because eligibility staff will no longer receive the MS-2156 directly from the provider, there may be instances where follow-up contact is necessary to ensure the determination process is progressing appropriately. It is anticipated that the majority of requests will be processed within fifteen working days from the point the MS-2156 is initiated, so staff should allow a minimum of ten working days prior to contacting BC/BS to check on the status of a request, unless immediate processing is needed. Staff may chose to follow-up directly with the provider to ensure the form was routed to BC/BS.

4. The Specialist will then make a final determination of eligibility based on the information provided by the fiscal agent. During this time, BC/BS staff will consistently check to determine if eligibility has been established and is displayed on MMIS. Once it is present, the necessary information will be loaded onto the MMIS to ensure proper payment of Medicaid claims. Because BC/BS staff cannot input information into the MMIS until the beneficiary is known to the system, it is helpful to advise them if eligibility is anticipated to pend beyond two weeks from the date the MS-2156 is received in the local office.

Hospital providers will be notified of the new procedure in a formal association meeting conducted by the fiscal agent. Provider manual updates are also planned as well as updates during provider meetings. Providers with questions should be referred to their local provider representative. Eligibility staff may contact fiscal agent staff Carol Samuelson (carol.samuelson@bcbsks.com) or Michele Hay (michele.hay@bcbsks.com) for questions regarding the status of specific determinations. If you have any questions regarding the new procedure please contact Terry at (785) 296-3349 or Jeanine (785) 296-8866.

JS:TD:jmm

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