MEDICAL NECESSITY

» All orders of elective procedures are subject to a medical-necessity review due to limited coverage for some services by the MCHD Indigent program.

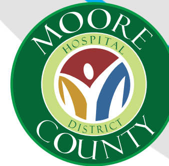
» For all elective surgeries for an indigent patient, a medical necessity record review needs to be completed prior to surgery. (This does not apply to emergency services.)

» MCHD Patient Financial Services will obtain information needed from the patient/ attending physician to forward for medical necessity review.

» MCHD Patient Financial Services will notify the attending physician and the patient on determination of review. If approved, the patient will be notified by a phone call and an eligibility form via mail.

REFERRAL PROCEDURE

1. The Moore County physician must write an order and statement of medical necessity prior to setting an appointment with the out-of-County physician. This order and statement must be sent to Patient Financial Services (for Administrative approval to pay for any services out of Moore County.) This does not apply to Emergency transfers from the hospital.
2. Patient Financial Services will start the administrative process for approval or denial of out-of-County payments.
3. Upon approval or denial, we will send a letter/form to the patient.



Moore County Hospital District
224 E 2nd St
Dumas, TX 79029
(806) 935-7171
www.MCHD.net

FILING PROCEDURES

- For physicians who choose to accept the patient as indigent eligible, please forward all bills to Accounts Payable, attn: Indigent Program, for payment.
- Clean claims must be received in Accounts Payable within 95 days of services and/or retro eligibility.
- If a claim is returned, our AP will send a letter explaining what needs to be corrected along with the date the claim must be returned in order to be considered for payment.

INDIGENT HEALTH CARE PROGRAM

Moore County Hospital District
(806) 935-7171
www.MCHD.net

Exceptional Care. Always.

GENERAL ELIGIBILITY

Household Composition:
The household consists of those persons living together who have a legal responsibility for each other.

Household members who are eligible for Medicaid are *excluded* from the household when determining eligibility for the Indigent program.

Residency:
An applicant *must* live in and *must* intend to remain in the county in which they apply.

Income:
Regular and predictable income received in one month, and is likely to be received in the next month, or was received on a regular and predictable basis in past months, or is more than the maximum income limit for the household's size.

Resources:
Household resources may not exceed$2,000.oo (or $3,000.00 if a relative who is aged or disabled lives with the household) per month.

COVERED SERVICES

- Up to three prescriptions a month for medications, according to indigent coverage guidelines
- Primary and preventive care services
- Immunizations and medical screenings
- Inpatient and outpatient services
- Rural health clinics
- Laboratory (with CLIA#) and radiology/imaging services
- Family planning services
- Physician services
- Skilled nursing facility services

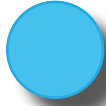
NON-COVERED SERVICES

Services that are not covered by the Indigent Health Care program need prior Administrative approval if requested by a primary care physician based on medical necessity.

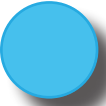
The following are typically non-covered services:

- Durable medical equipment (DME) and medical supplies.
- Dental Care
- Vision Care
- Ambulatory Surgical Centers

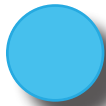
DETERMINING ELIGIBILITY



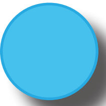
The patient will be given an Indigent Healthcare Program application to complete. Every item in the application must be completed.



After the patient returns the completed application, they will be screened by MCHD Patient Financial Services (as per State guidelines) to determine if they will either be approved or denied for indigent benefits.



The eligibility time frame will be determined depending on the circumstances of the applicant. A person may apply monthly if their income fluctuates, but this will cause a retro-coverage versus prior approval notification.



Special consideration is made through the Indigent care program to recipients that are applying for and/or appealing SSI Medicaid. All services for those recipients are only covered for benefits if the Provider supplying services signs a Provider agreement form that stated the Provider will bill Medicaid when the recipient becomes eligible.

When the retro Medicaid is billed and the provider is paid, the provider agrees to reimburse the MCHD Indigent Care Program.

Please note the provider agrees to bill the retro Medicaid within the 95 days filing time, as required by Medicaid.