Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP)
Programs Manual

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HIPP Programs General Information

I. Program Background

1. Introduction

The Commonwealth of Virginia has two Medicaid related premium assistance programs that are administered by the Department of Medical Assistance Services (DMAS):

- the Health Insurance Premium Payment (HIPP) For Kids Program which is a premium assistance program for those Medicaid members under the age of 19 who are eligible for or enrolled in "qualified employer-sponsored coverage," and

- the Health Insurance Premium Payment (HIPP) Program when determined to be cost effective is a cost saving program for Medicaid members and reimburses some or all of the employee portion of the group health insurance premium for members who have employer sponsored group health insurance available to them through their own or their family member's employment or who has COBRA coverage.

All applications for premium assistance are first evaluated for the HIPP for Kids program. If it is determined that the eligibility criteria for the HIPP for Kids program are not met, the application is automatically evaluated for the HIPP program.

2. Legal Base

The HIPP program is established under Section 1906 of the Social Security Act. Effective July 23, 2009, the HIPP program became an optional program under the Medicaid Program. The Virginia Administrative Code (VAC); 12VAC30-20-210; State method on cost effectiveness of employer-based group health plans; 12VAC30-20-211 , State method on cost effectiveness of employer-based group health plans – individual and family plans; 12VAC30-130-750, Time frames for determining cost effectiveness; and 12VAC30-130-790, Information required of applicants and recipients.

The HIPP for Kids program is established under Section 1906A of the Social Security Act (SSA),the 2010 Appropriations Act, Chapter 874 Item 296 L; and the VAC; 12VAC30-20-205, Heath Insurance Premium Payment Program for Kids.

3. Program Information

Information regarding the HIPP programs is available on the DMAS website at http://www.dmas.virginia.gov/#/hipp, by emailing the HIPP Unit at hippcustomerservice@dmas.virginia.gov or by calling toll-free helpline 1-800-432-5924.

II. Confidentiality

HIPP applicants and members are protected by Medicaid federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

1. Release of Participant Information

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any participant information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid HIPP program, which includes but is not limited to:

- establishing eligibility;
- determining the amount of premium subsidy assistance; and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

2. Release to Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives. The designation must be in writing, with the applicant or participant specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

3. Safeguarding Client Information

All information associated with an applicant or participant that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the participant;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of premium assistance subsidy payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of member appeals.

4. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated. Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

5. Release of Participant Information <u>with</u> Consent Form

As part of the application process for the HIPP Programs, the participant shall be informed of the need to consent to the release of information necessary for verifying eligibility. Additionally, when an application is received and the Medicaid eligible family member is not living in the same household as the employee/policyholder with the insurance coverage, a HIPP Consent Form must be received from both:

- the parent/legal guardian of the household in which the Medicaid eligible member resides or the Medicaid member if age 18 or older, and
- the policy holder of the insurance coverage.

6. Release of Participant Information <u>without</u> Consent Form

Information from the applicant/participants case record may not be released to other agencies, with the exception of the Department of Social Services without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with INS, the State Verification Exchange System (SVES) with the Social Security Administration, etcetera.
Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

7. Client's Right of Access to Information

A. Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality.

B. Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and members during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

C. The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- all personal information about the client except as provided in §2.2-3704 and §2.2-3705, and
- the identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

D. Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

III. Definitions

Applicant	means the person who signed the HIPP Application Form, may be the parent or guardian living in the same household with the Medicaid eligible family member, the parent or guardian who is employed and is the policy holder of the insurance coverage, or the Medicaid eligible family member if age 18 or older
Application Date	means the date on which the HIPP application form was received at the DMAS

Authorized Representative means a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until:

- the application is denied;
- the premium assistance enrollment is canceled; or
- the individual changes his authorized representative

Case means all persons who are living in the same household who are eligible for coverage under the group health plan and who are eligible for Medicaid

Comprehensive Health Coverage means coverage that is comparable to services offered under the Medicaid State Plan and provide at a minimum the following services: physician services, in and outpatient hospitalization, prescription drugs, outpatient labs, shots and x-rays

Cost Effective and Cost Effectiveness means that it is likely to cost the state less to pay for the premiums of employer sponsored health insurance including the copayments and other cost sharing amounts than to otherwise cover under the Medicaid program

Employer-based means that the policy holder is an employee or retiree of the employer that provides the coverage for the individual and his family (coverage that continues as a survivor benefit for a spouse/family member of a deceased individual must be provided through the spouse's employer)

Family Member means individuals who are related by blood, marriage, or adoption

Group health plan means a plan which meets § 5000(b) (1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Service Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees

High Deductible Health Plan (HDHP) means a health care plan with a deductible range that is equal to or greater than the levels set by the IRS and is considered a HDHP for HIPP programs' purposes as defined under Internal Revenue Code § 223(c)(2) and without regard to whether the plan is purchased in conjunction with a health savings account with an annual deductible that must be less than the deductible amount set by Department of Treasury for a HDHP; see Appendix 5

HIPP	means Health Insurance Premium Payment programs, which are premium assistance programs. Virginia offers 2 programs for Medicaid eligible members' under1906 and 1906A of the Social Security Act
Medicaid Eligible	means an individual who is eligible for full-coverage Medicaid that was not achieved by meeting a spend-down or who was only eligible retroactively
Medicaid Covered Services	means a procedure Medicaid deems reimbursable and adheres to requirements under the State Plan
Participant	means an individual who is approved for a HIPP Program
Premium	means the fixed cost of participation in the group health plan, which may be shared by the employer and employee or paid in full by either party
Premium Assistance Subsidy	means the amount of the employee's contribution for enrollment in the qualified employer-sponsored coverage by the individual under age 19 or by the under age 19 individual's family
Recoupment	means the process by which overpayment of health insurance premiums to the participants are recovered by the DMAS
Qualified Employer-Sponsored Coverage	means a group health plan or health insurance coverage offered through an employer that qualifies as creditable coverage under section 2701(c)(1) of the Public Health Service Act; the employer contribution toward any premium for such coverage is at least 40 percent.
Explanation of Benefits	(**EOB**) means a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf
Current Procedural Terminology	(**CPT**) means a code that identifies medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

Applications and Entitlement

I. Right to Apply

An individual cannot be refused the right to complete an application for himself or herself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or herself or any person for whom he is a legally responsible or authorized to represent. An application can be downloaded from the DMAS internet website site at, http://www.dmas.virginia.gov/#/hipp or by calling the HIPP program at 1-800-432-5924 or sending an email to hippcustomerservice@dmas.virginia.gov .

II. Who Can Sign the Application

1. The applicant must be age 18 or older to apply to the HIPP programs. The applicant may be the Medicaid eligible family member, the employee/policy holder and/or the parent/guardian of the Medicaid eligible family member or authorized representative.

2. HIPP program applicants not living in the same household as Medicaid eligible family member-

   A parent who is the policy holder of the employer-based health insurance may apply to the HIPP programs on behalf of the Medicaid eligible family member if not residing in the same household.

   Please note that Medicaid eligibility information may not be provided to someone who is not the Medicaid Applicant and not living in the same household unless written consent is granted from the applicant, if age 18 or older, or the parent/guardian with whom the family member resides.

III. HIPP Application Forms

A HIPP application must be submitted on the form(s) prescribed by DMAS. A complete application for the HIPP programs must be signed and consists of the following documents:

- HIPP Programs Application/Renewal Form, and
- Employer Insurance Verification Form (EIV).

The application must be signed by either the Employee, the Medicaid eligible family member if age 18 or older, or the parent/guardian/authorized representative of the Medicaid eligible family member. The Employer Insurance Verification Form must be signed by the Employer Representative or if self employed, the self employed person. Retirees who do not have access to a local employer benefit office may complete and sign the Employer Insurance Verification Form in place of the employer. All requested information on the EIV must be completed. If additional information is needed, you will be notified.

1. Place and Date of Application

   The place of application is the Department of Medical Assistance Services (DMAS). The date of application is the date the HIPP Unit receives the application/renewal form. If the application/renewal form is not received by DMAS, a valid request to apply to the HIPP programs is considered not to have occurred.

2. Required Documents for Application Evaluation for the HIPP Programs

   A. In order to complete an evaluation for eligibility for the program the following documents must be submitted:

      - Completed and signed HIPP Programs Application/Renewal Form;
      - Completed and signed Employer Insurance Verification Form (EIV);
      - Copy, front and back of health insurance cards (medical, dental, pharmacy and/or vision);
      - Copy, front and back of Insurance Summary of Benefits page(s);
      - Copy of most recent pay stub showing health insurance premium deduction or if premium is not deducted from pay stub, documentation from employer/insurance company showing the employee's responsibility for the health insurance premium to include a copy of the canceled check or money order supporting payment of the insurance premium; and
      - If self employed – most recent completed tax returns to include all attachments and business records, if applicable, in addition to submission of the premium payment documentation requirements noted in e above; or
      - Documentation from employer showing employer contribution to health plan/coverage premium.
      - COBRA- COBRA confirmation of coverage notice that includes who is covered and the coverage periods.
        a. COBRA verifications <u>must be submitted</u> monthly

IV. Application Processing Time Standards

Applications must be processed within 45 calendar days of application date. However, if all required documentation for evaluation of an application is not provided within 30 calendar days of the application date, the application will be denied. The Department must allow at least 10 calendar days from the date of the checklist to receive information requested that is necessary to processing the application/renewal prior to processing.

If the HIPP Application/Renewal Form is not received by DMAS, no formal request to apply to the HIPP Programs has occurred. DMAS will send a HIPP Application if other information, such as an EIV Form, has been submitted to the HIPP Unit. The applicant will have 10 days from the date the application was mailed to complete and submit the application from. Failure to submit a <u>completed</u> HIPP application within 30 days of the initial request will result in no further action being taken by the HIPP Unit.

V. Application Processing

If the application contains a Medicaid eligible family member under age 19, the application will first be evaluated under 1906A of the SSA, for the HIPP for Kids program. If determined eligible for the HIPP for Kids the case will then be enrolled in HIPP for Kids. If the HIPP for Kids program requirements are not met, the application will then be evaluated for cost effectiveness to determine whether the application meets the requirements for HIPP under Section 1906 of the SSA. If the reason the HIPP for Kids requirements are not met is the failure of the employer to provide the necessary information, the participant will be given the opportunity to obtain the information within a 30 day timeframe and request an evaluation be completed.

VI. Application Disposition

Each application must be disposed of by a finding of Approved or Denied. Applicants must be notified in writing of the finding. Applicants who request withdrawal of application must also be sent written notification that the application was denied as the applicant withdrew the application.

VII. Entitlement

1. Approvals

   The applicant will be notified if the application has been approved, and the notice will include the effective date(s) of enrollment.

   - For HIPP for Kids, the approval date is the 1st day of the following month in which the application is received or the date in which the health insurance coverage begins, whichever is the later.

   - For HIPP, the approval date is the 1st day of the following month in which the application is received or the date, in which the health insurance coverage begins, whichever is the later.

2. Denials - The applicant will be notified if the application is denied, including the denial reason.

HIPP for Kids and HIPP Eligibility Requirements

HIPP for Kids Eligibility Requirements

All applications/renwewals are first evaluated for the HIPP for Kids program. If the programs criteria are not met the application/renewal is then evaluated for the HIPP program.

I. Member Eligibility

1. The following requirements are evaluated and must be met:

A. Eligible family member must be under age 19 and enrolled in full coverage Medicaid;
B. Eligible family member must be living in the household of the parent/policy holder of the employer group health plan.
C. Eligible family member must be enrolled or eligible for enrollment in the qualified employer-sponsored coverage (does not include deceased individuals);
D. Health insurance plan must meet “qualified employer-sponsored coverage” requiremments.

II. Qualified Employer Sponsored Coverage

1. The following requirements are evaluated and must be met:

A. Health plan/coverage shall be verified through the EIV and if necessary; contact with the employer representative and/or insurance company;
B. Medicaid eligible family member under age 19 must be covered or eligible for coverage under the health plan;
C. The group health plan or health insurance coverage offered through an employer must meet requirements for "qualified employer-sponsored coverage":

- must qualify as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;
- the employer contribution toward the premium must be at least 40 percent;
- does not include benefits provided under a health flexible spending arrangement (as defined in section 106(c) of the Internal Revenue Code of 1986);
- does not include a high deductible health plan as defined in section §223(c) (2) of the Internal Revenue Code of 1986. HDHPs do not meet the definition of qualified employer-sponsored coverage.

D. To qualify as “self-employed” for this program, the income obtained through self-employment activities must be the family’s primary source of income. Family for this purpose includes family by “blood, marriage or adoption.”
E. If a Medicaid eligible member is covered by one or more qualified employer-sponsored coverage, only one plan will be evaluated for the HIPP for Kids program.

III. Program Requirements

The HIPP for Kids program must verify all of the following eligibility requirements:

- Enrollment in "qualified employer-sponsored coverage" for Medicaid eligible family member under age 19
- Health plan covered services and deductibles
- Health plan meets requirement of "qualified employer-sponsored coverage"
- Employee and employer cost of employer health insurance
- For self-employed individuals, health insurance coverage may meet qualified employer-sponsored coverage requirements if the income obtained through self-employment activities is the family's primary source of income and the insurance meets the first three requirements above.

Eligibility requirements will be verified by using documentation submitted by applicant or if information is not available, initiate contact with the employer and/or health insurance plan.

IV. Premium Assistance Subsidy

If all eligibility requirements are met, the employee's share of the qualified employer-sponsored coverage will be reimbursed. The premium assistance subsidy only includes medical coverage. The subsidy does not include payment for dental premiums or other benefits that are not included in the health benefit plan, such as vision services, if the premium is deducted separately. The premium assistance subsidy is a reimbursement and the payment is processed for the month following the month the expense was incurred.

V. Reimbursement for Cost Sharing Expenses

Deductibles, coinsurance and other cost-sharing for items and services covered under the qualified employer-sponsored coverage that are also covered under the Medicaid state plan may be reimbursed up to the employer-sponsored coverage limit, if one is applicable, but not to exceed the Medicaid Service limit for the Medicaid eligible member under 19 and parent provided criteria are met.

1. Cost Sharing Reimbursement Criteria-

A. Verifications can only be submitted for dates of service (DOS) that occurred on or after the effective date of the HIPP for Kids application approval and within the appropriate verification quarter.
B. Reimbursement is processed on a quarterly basis and checks are disbursed the last Friday of the month following the verification month.

C. An Explanation of Benefits (EOB) from the insurance company must be submitted showing:

- DOS;
- that the expense is the responsibility of the member and/or parent;
- that the expense was paid prior to the submission of the request; and

- sufficient identification codes for the DOS to enable DMAS to determine if the service or medication is reimbursable before applying the remaining cost sharing criteria.

D. A Medical Expense Period form and all supporting documentation must be received at DMAS no later than the 5th month in which verification is due in order for the reimbursement of costs to be processed within the Verification Month.

E. All medical expenses, including co-pays & deductibles, must be paid before reimbursement can be made.

F. The chart below indicates the expense periods, corresponding verification months and months in which reimbursement is received when the verification is received by the due date.

Medical Expense Period	Verification Month & Due Date	Reimbursement Disbursed
January thru March	May 5th	June
April thru June	August 5th	September
July thru September	November 5th	December
October thru December	February 5th	March

VI. Cost Sharing Reimbursement Processing

The HIPP for Kids program provides payment for deductibles, coinsurance, and co-pays obligations for services otherwise covered under the State plan under Medicaid.

1. When processing documentation submitted for cost sharing, the following applies to the Medicaid eligible family members who are under the age of 19:

A. When receiving services from a contracted Virginia Medicaid provider, co-payments and deductibles, may be paid for the Medicaid eligible under the age of 19 when the provider submits the claim to Medicaid.
B. If the servicing provider of the Medicaid member is not a Medicaid provider and the service is covered by the employer sponsored health plan and is a covered service under the Medicaid State Plan, HIPP for Kids may provide payment of the co-payments, co-insurance and deductibles.
C. If a medical service is not covered by your employer's insurance, but is covered by Medicaid, Medicaid may pay for the service as long as you see a Medicaid provider. Medicaid providers are listed on the DMAS website at www.dmas.virginia.gov/provider_search.ASP, or you can contact the Recipient Help Line at (804) 786-6145.

D. No payment is available for co-insurance or deductibles for services rendered by providers who do not participate in the member's employer sponsored group health plan (out of network charges) or do not participate in the Medicaid program.
E. No payment is available for services that were paid for by and/ or through FSA (flexible spending account); HRA (Health Reimbursement Account) and/ or a MSA (Medical Savings Account). See Appendix 8.
F. Photo copies of prescription bottles and handwritten/ typewritten is not acceptable documentation. All documentation must be submitted on letterhead from the providers and / or facilities.

2. When processing documentation submitted for cost sharing, the following applies to the parent enrolled in a qualified employer-sponsored group health plan that has been approved for HIPP for Kids:

A. When receiving services covered by the qualified employer-sponsored health plan, HIPP for Kids will provide reimbursement for payments that have been made for the parent's co-pay, co-insurance and/or deductible for items and services covered under the State Plan for Medicaid Services
B. No payment is available for items and services rendered to the Medicaid eligible' s parent if the item/service is not covered by the employer sponsored health plan.
C. No payment is available for co-insurance or deductibles for services rendered by providers who do not participate in the member's employer sponsored group health plan (out of network charges).

V. Reporting Changes

Changes that affect participation if the HIPP Programs <u>must be reported</u> no later than 10 calendar days from the date the change occurred. Changes that are to be reported include but are not limited to:

- Family member under the age of 19 dropped from health insurance plan or dropping health insurance plan completely;
- Change in health insurance plan or health plan coverage;
- Change in employer resulting in change in health insurance plan;
- Change in employer contribution to the health plan premium cost;
- Change in employment status (lay off/termination, short-term disability); and
- Address changes.

HIPP Program Requirements

HIPP Programs applications/renewals are first evaluated for the HIPP for Kids program. If the eligibility criteria for the HIPP for KIDS program are not met, the application/renewal is then evaluated for the HIPP program. The comprehensive employer based group health insurance plan must have an effective begin date within the application processing timeframe, otherwise the application will be denied.

Premium payments for separate comprehensive employer based group dental and vision plans will be included in the evaluation for individuals less than 21 years of age when held by the policy holder of the group health insurance plan.

I. Member Eligibility

The following are the general eligibility criteria that must be met in order for an evaluation for HIPP to be completed:

- a family member must be enrolled in full coverage Medicaid;
- a Consent Form signed by the responsible person and the policy holder authorizing release of Medicaid eligibility information must be provided if the Medicaid eligible does not reside in the household as the policy holder.
- be enrolled in the comprehensive employer group health insurance plan.

If the criteria above are met, then the plan meets the first criterion for cost effectiveness. The next step in the cost effectiveness determination is completing the cost evaluation. This step determines if full or partial reimbursement of the health insurance premium will be paid. A plan must be determined cost effective for full reimbursement of the health insurance premium.

II. HIPP Cost Effectiveness Determination

1. Health Insurance Coverage Criteria

Health Insurance Coverage information will be verified through the EIV or contact with the employer representative and/or insurance company. If the plan is determined to be a comprehensive group health insurance, then the cost evaluation to determine cost effectiveness will be completed. If the plan does not meet criteria then the application/renewal will be denied.

A. Medicaid eligible family member must be covered under the health plan.

B. Health insurance coverage must be comprehensive, (i.e. comparable to the Medicaid State Plan coverage) and at a minimum provide the following services:

- Physican Services;
- In and Out Patient Hospitalization;
- Outpatient labs, shots and x-rays; and
- Prescription Drug.

C. Coverage cannot be a plan that provides a limited benefit such as plans that only provide a maximun payment per day for hospitalization. Example-Hospital Indemnity Plans

D. COBRA is eligible for evaluation for HIPP.

E. Medicare coverage - Medicaid eligible family members enrolled in Medicare Part A and/or Part B are not eligible for HIPP.

F. Zero Premiums- Health Insurance coverage where there is no contribution from the employee.

G. Deductibles - annual deductible must be less than the deductible amount as set by Department of Treasury for a High Deductible Health Plan (HDHP). The amount is updated annually by the Department of Treasury, see Appendix 2.

H. Existing family health coverage must be an eligible health plan. If the health plan is family coverage (i.e. consists of 3 or more family members), household members covered under the health plan will be evaluated according to the Eligible Family Health Plan Chart, see Appendix 1.

2. HIPP Health Insurance Cost Evaluation

The following is the evaluation used to determine the monthly cost of the employee share of the health insurance premium deduction:

A. Monthly Cost of Employee Share of Health Insurance Premium Deduction Calculation

1. Obtain the employee share of the cost for the monthly premium deduction amount
2. Determine the deduction frequency (weekly, biweekly, etc.) and number of pay periods in the year from which the insurance premium is deducted.
3. Multiply the premium deduction amount by the frequency of pay period /number of months in year 12 or 10 (some school employees).

<u>Example</u>- *Monthly premium deduction is $50/pay period, pay period frequency is weekly and deductions are taken out 52 times. Calculation is $50 x 52 weeks = $2600. Monthly premium assistance amount is $2600/12 months = $216.67 per month.

**Cost of dental and/or vision premiums are included in the cost evaluation if the Medicaid eligible family member(s) under 21 years of age is covered by the dental/vision plan(s).*

B. Monthly Medical Cost /HIPP Cost Effectiveness Rate Calculation

The HIPP cost effectiveness rate is calculated for each Medicaid eligible family member.

1. The HIPP Rate Chart is used to obtain the Cost Effectiveness Rate (average medical cost) for each Medicaid eligible based on the age, gender, *Medicaid enrollment category and geographical region of the state where the family member resides.
2. The HIPP cost effectiveness rate for all Medicaid eligible family members is added together to obtain the total.

*__Note__: Individuals receiving long term care services are always evaluated in the Aged, Blind, and Disabled group.

C. HIPP Cost Evaluation

The Monthly Premium Cost in 2A above is compared to the total Monthly Medical Cost/HIPP Cost Effectiveness Rate in 2B above to determine the extent of the reimbursement permitted under HIPP.

1. If the Monthly Health Insurance Cost is less than Monthly Medical Cost/HIPP Cost Effectiveness Amount, the application is cost effective and approved for full reimbursement of the premium cost.
2. If Monthly Health Insurance Cost is greater than Monthly Medical Cost/HIPP Cost Effectiveness Amount, the application is not cost effective; DMAS will provide partial reimbursement of premium cost up to the lesser of the Monthly Medical Cost or HIPP Cost Effectiveness Amount.

I. Reporting Changes

Changes that affect participation in the HIPP Programs <u>must be reported</u> no later than 10 calendar days from the date the change occurred. Changes that are to be reported include but are not limited to:

- Family member under the age of 19 dropped from health insurance plan or dropping health insurance plan completely;
- Change in health insurance plan or health plan coverage;
- Change in employer resulting in change in health insurance plan;
- Change in employer contribution to the health plan premium cost;
- Change in employment status (lay off/termination, short-term disability), and
- Address changes.

Health Insurance Premium Payment Processing

I. General Information

The first month for which reimbursement of the health insurance premiums will be provided under the HIPP for Kids program is the month following in which a completed application was received or the month in which the qualified employer-sponsored coverage is effective, whichever is later. The first month for which reimbursement of the health insurance premiums will be provided under the HIPP program is the first day of the month following the month in which the cost effectiveness determination was made or the first day in the month in which the comprehensive employer based coverage is effective, whichever is later.

Examples-

1. HIPP for Kids approved for a completed application received in January and the qualified employer-sponsored coverage is already in effect. The first month for which reimbursement will be provided for the health insurance premiums paid by the participant is February.

2. HIPP approved for a cost effectiveness determination completed in January and the comprehensive employer based coverage is already in effect. The first month for which reimbursement will be provided for the health insurance premiums paid by the participant is February.

The HIPP programs verify continued enrollment in the health care plan by obtaining documentation that the health insurance premium was paid. Documentation is obtained on a quarterly basis. The months included in the quarter for which documentation is to be provided is based on the month in which the application for the HIPP programs was received. The months in which the verification or documentation are due are provided on the notice to the participants at the time of application approval or renewal.

Example-The HIPP Programs application was received by DMAS in April. Future documentation of the health insurance premium deductions will be due in the months of July, October, January and April. Please refer to section **VII** below for information on which month's documentation is due.

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Documentation due			**Application Month Documentation due**			**Documentation due**			**Documentation due**		

Participants whose employment is less than 12 months a year, such as school or seasonal employees may be required to report on something other than a quarterly basis. Retirees, whose documentation is provided by their pension or health plan on a yearly basis and do not receive a monthly statement, may report less frequently. The months in which the verification or documentation are due are provided on the notice to the participants at the time of application approval or renewal.

All participants should note that the reporting of changes that affect HIPP eligibility or reimbursement is a program requirement. Failure to report changes may result in referral to the DMAS Recipient Audit Unit for possible fraud.

Premium subsidy reimbursement checks are issued monthly for participants who continue to meet the program participation requirements. Reimbursement checks are issued on the last Friday of each month for the **previous** month's premium cost. Reimbursement checks can be issued to the employee (policy holder), employer or Health Insurance Company.

II. School Employees, Retirees and Employees with Seasonal Employment

Participants are only reimbursed for the employee cost of the health insurance premium for months in which the participant has the deduction. If there is no premium deduction during a month, no reimbursement payment is issued for that month.

School Employees working 10 months, who receive wages for only 10 months will only receive reimbursement checks for the months in which the premium is deducted. No reimbursement check is issued for a month in which there is no premium deduction.

Seasonal and other employees who have irregular pay schedules are only reimbursed the cost of the employee health premium for the month(s) in which the employee has an expense. The number of times these types of employees send documentation of their premium costs may be more frequent than individuals who are employed 12 months per year.

Retirees whose premium payment documentation is provided directly by the health plan and is not provided each month may send documentation less frequently.

III. Acceptable Types of Documentation

The following are the types of verification that are acceptable for documenting health insurance premium deductions:

- the last paystub received in the month prior to the month in which verification is due showing the premium deduction amount;
- a receipt from the employer or insurance company along with a copy of the canceled checks or money orders demonstrating the cost of the insurance for the quarter has been paid, if the participant's pay stub does not reflect the health insurance deduction; or
- for retirees who only receive a yearly statement of their insurance premium deduction amount at the beginning of the health plan year and are not provided with a monthly statement, the <u>most current</u> annual statement when received by the participant must be provided.

IV. When Premium Deduction Verification is due

Documentation must be submitted by the 5th of the month in which it is due. If the 5th falls on a weekend day or a holiday, the due date is the next business day. Documentation received after the 5th of each month is considered late and the reimbursement will not be processed within the month in which the verification was due. Late documentation will be held and processed the next month.

Example-Verification documenting the premium deductions for the months of January, February and March are due by April 5th. Documentation is not provided until April 20th; therefore, the reimbursement check will be processed in May. Had the documentation been received by April 5th then the reimbursement check would be processed in April. Reimbursement checks are generally received the beginning of the month after the month in which they are processed.

V. Ineligibility for Reimbursement Payments

Reimbursement checks will not be issued for the following reasons:

- valid documentation of the premium deduction was not provided in the month in which it was due;
- employee has no premium deduction for health insurance cost for a month(s);
- no Medicaid eligible family member is covered under the health insurance plan;
- Medicaid eligible family member turned age 19 (HIPP for Kids); or
- Health Plan/coverage no longer meets requirement for qualified employer-sponsored coverage.

VI. Suspension of Reimbursement Payment

Payments will be suspended for the following reasons:

- change reported in employer and/or health insurance plan and re-evaluation not completed;
- change reported in employer and/or health insurance plan and information necessary to determine if coverage meets the requirement of "qualified employer-sponsored coverage" has not been received;
- documentation of premium payment verification not received; or
- documentation of premium payment verification received late and processing delayed until the next month.

VII. Payment Notification Requirements

Ten day advance notice is required prior to reducing or suspending payment on a case. DMAS is not required to provide advance notice when a payment is not issued because the documentation showing payment of premium amounts for the prior quarter was not provided by the participant to validate prior reimbursements. DMAS will send notification in the month in which the documentation was due indicating that the next payment is not being made because documentation was not received or was not received in a timely manner.

VIII. Issuance of Supplemental Payments

Documentation must show that premium payments were deducted and or paid for the quarter for which the participant is reporting. Once documentation is received, it will be reviewed to ensure that the payments that were paid over the last quarter or three months were correct. When it is determined that the reimbursement payments issued by the program were less than what had been paid over the quarter by the participant, a supplemental reimbursement check will be issued.

IX. Recoupment of Overpayments

Documentation must show that premium payments were deducted and or paid for the quarter for which the participant is reporting. Once documentation is received, it will be reviewed to ensure that the payments that were paid over the last quarter were correct. When it is determined that the payments made by the program were greater than what had been paid by the participant and the case remains active, the overpayment will be recouped by the program by lowering future payments to the participant. Advance notice is required prior to reducing a participant's reimbursement payment. The recoupment process also applies to cost sharing reimbursement payments for the HIPP for Kids program.

When a case is no longer active and recoupment is not possible, any overpayment will be referred to the DMAS Recipient Audit Unit for possible fraud and collection of the reimbursement over issuance.

X. Check Issuance

Reimbursement checks are issued and mailed on the fourth Friday of each month for participants whose verification was received within the appropriate timeframe. For those participants whose verification was not received within the appropriate timeframe, payment will be issued the following month on the *last* Friday. Participants should allow 10 days for receipt of the check before inquiring with the HIPP Unit. Please note that for the calendar month of June only, reimbursement is paid on the first Friday of July due to the requirements of the Virginia 2012 Appropriation Act...

Continuing Eligibility

I. Annual Renewal

Renewal of eligibility must be completed at least every 12 months. Participants will be sent the HIPP Application/Renewal and the EIV Forms to be completed and submitted to DMAS for re-evaluation of HIPP Programs eligibility. The evaluation for renewal must be completed no later than the last day of the 12th month from the application month in order for eligibility to continue without interruption. Once eligibility has been evaluated and a decision rendered, the participant will be notified in writing of the result(s) of the evaluation.

When the reason for cancellation was failure to return all required verifications and the participant sends all verifications necessary to determine continuing eligibility to DMAS within the time periods below, a new HIPP application will not be required:

- prior to the effective date of cancellation; or
- by the last day of the month following month in which participation was cancelled.

II. Change Reported

When a change is reported by a participant, employer or Insurance Company, the case analyst has 30 days from the date the change was reported to DMAS to evaluate the change and determine the effect on the participant's eligibility. If the change has the potential to affect the amount of reimbursement the participant receives, payment will be suspended until an evaluation can be completed.

III. HIPP for Kids

Once an application is approved, the HIPP for Kids case eligible family member must continue to meet the following eligibility criteria:

- remain enrolled in a health plan that meets the requirements of qualified employer-sponsored coverage;
- remain enrolled in full coverage Medicaid; and
- must be under age 19. (See Chapter 3 for detailed information)

IV. HIPP

Once an application is approved the HIPP case participants must continue to meet the following eligibility criteria used in the cost effectiveness determination:

- must remain enrolled in the employer group health plan; and
- remain Medicaid eligible. (See Chapter 3 for detailed information)

V. Health Insurance Premium Verification

Participants must continue to provide documentation on a quarterly basis of the of health insurance premium paid for the prior months. The notice provided to the participant at the time of approval of the application or at the time of renewal provides a list of the months in which the documentation is due.

VI. Program Cancellation

Cancellation from the HIPP Programs will result for the following reasons:

- No family member is eligible for Medicaid;
- The child turns 19 years old (HIPP for Kids);
- No longer enrolled in health insurance plan as a result of disenrollment from the health plan;
- No longer enrolled in health insurance plan as a result of change in employer;
- Health plan no longer meets the requirements for either HIPP Program;
- Failure to submit or complete annual renewal forms and/or provide documentation required to complete the renewal;
- Failure to provide signed Consent Form when Medicaid eligible family member is not residing in the same household as the policy holder (employee);
- Failure to submit required documentation of incurred health insurance costs (first month payment is suspended, second consecutive month cancellation occurs);
- Failure to meet programmatic requirements; or
- The participant requests closure of the HIPP Programs case.

Cancellation of the HIPP programs case and premium payment is effective the last day of the month in which adequate notice, when appropriate or advance notice is given. The effective date of cancellation is indicated on the notice and cites the reason for cancellation.

VII. Cancellation Notification Requirements

Ten day advance notice is required for most decisions prior to DMAS cancelling participation in the either HIPP program. However, only adequate notice is required when the following actions are taken to inform the household that premium payments are being discontinued because:

- Medicaid eligibility has been lost by all persons covered under the group health plan;
- the group health insurance plan is no longer available to the family (i.e. the employer drops insurance coverage or the plan is terminated by the insurance company); or
- DMAS has determined it is no longer cost effective to pay the premiums.

The written notification must provide the effective date of termination and cite the reason(s) for cancellation.

VIII. Appeal Rights

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce premium assistance;
- fails to take an application for premium assistance;
- fails to act on an application for premium assistance with reasonable promptness; or
- takes any other action that adversely affects receipt of premium assistance.

A. Notification and Rights

At the time of application or redeterminations, and at the time of any action or proposed action affecting payment of premium assistance, the applicant for and participant of premium assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesperson.

B. Appeal Request Procedures

An appeal is a request for a fair hearing. The request must be a clear, written expression by an applicant or member, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."

C. Where to File an Appeal

Appeals must be sent to the:

Department of Medical Assistance Services
Appeals Division, 11th Floor
600 East Broad Street
Richmond, Virginia 23219

Appeals may also be faxed to (804) 452-5454

D. Appeal Time Standards

A request for an appeal must be made within 30 days of receipt of notification that premium assistance has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/participant within three days of the date the notice was mailed; unless the applicant/participant substantiates that the notice was not received in the three-day period through no fault of his/her own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or
- the date the request was faxed or hand-delivered.

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day. DMAS will, at its discretion, grant an extension of the time limit for requesting an appeal if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

Appendix 1

HIPP Family Health Plan Eligibility Determination:

The following chart is used to determine if a *Family Health Plan is an eligible plan:

Total Number of Family Member(s) on Health Plan **Not Enrolled** in Medicaid	Total Number of Family Member(s) on Health Plan **Enrolled** in Medicaid	Is the Family Health Plan an Eligible Plan? **Yes or No**
1 only	2 or more	**Yes**
2 only	1 or more	**Yes**
3 or more	1 or more	**No**

If there are 3 or more **total** family members enrolled in the family health plans who are not Medicaid eligible, the family plan is not eligible for HIPP regardless of the number of the Medicaid enrolled members on the plan. The following exceptions apply to this rule:

1. Family meets Family Access to Medical Insurance Security (FAMIS) eligibility criteria but cannot enroll non-Medicaid family members due to existing group health insurance; or
2. Medicaid eligibility is based on family income (Medicaid Family Unit) and the family members enrolled in the group health insurance are not Medicaid eligible because of age restrictions (i.e. age 19 years or older).

**A Family Health Plan is defined as a health plan having three or more covered members participating in the plan.*

Appendix 2

Department of Treasury HDHP Values Chart:

Year	Per Individual	Per family
2011	$1,200 or greater	$2,400 or greater
2012 ***(no change from 2011)***	$1,200 or greater	$2,400 or greater
2013	$1,250 or greater	$2,500 or greater
2014 ***(no change from 2013)***	$1,250 or greater	$2,500 or greater
2015	$1,300 or greater	$2,600 or greater
2016	$1,300 or greater	$2,600 or greater
2017 ***(no change from 2015)***	$1,300 or greater	$2, 600 or greater
2018	$1,350 or greater	$2,700 or greater
2019	$1,350 or greater	$2,700 or greater

Appendix 3

Medicaid covered and non-covered services-The following lists may not include all of the services that Medicaid may or may not cover and are intended for use as a general guide only:

HIPP for Kids Covered Services:

Clinic Services
Eyeglasses and repair for members under the age 21 (contacts are not covered unless medically necessary)
Eyeglass Frames Cost within the Medicaid Service Limit
Home Health Services within the Medicaid service limits of the specific service rendered
Hospice
Hospital Care (Inpatient and Outpatient)
Hospital Emergency Room Services
Laboratory services
Physician's Services
Prescription Drugs when ordered by a Physician and FDA approved
Psychiatric or Psychological Services, within Medicaid limits of 26 visits per year
Radiology services (x-rays, scans, etc.)
Renal (Kidney) Dialysis Clinic Services
Rehabilitation Services (excluding substance abuse)

HIPP for Kids Non-Covered Services:

Abortions
Acupuncture
Administrative expenses, such as completion of forms/copying of records
Artificial insemination, in-vitro fertilization, or other services to promote fertility
Broken appointment charges
Certain drugs not proven effective
Experimental medical and surgical procedures
Chiropractic services
Cosmetic treatment or surgery
Custodial Care
Dental services if you are 21 or older
Drugs prescribed to treat hair loss or to bleach the skin
Eyeglasses or their repair for age 21 or older
Eyeglass Frames Cost beyond the Medicaid Service Limit
Immunizations for age 21 older (except for flu and pneumonia for those at risk)
Items or services covered under workers' compensation law
Ninety-day Prescriptions/Maintenance Prescriptions
Out of Network services and providers
Personal care services (other than services under an appropriate Medicaid waiver)
Prescriptions that are not part of the Preferred Drug List
(https://www.virginiamedicaidpharmacyservices.com/)
Preventive medical care for age 21 and older (except annual PAP smear for females over age 21 and older)
Private Duty Nursing (other than services under an appropriate Medicaid waiver)
Psychological testing done for an educational diagnosis, or institution admission and/or placement or upon court order

Remedial education
Routine foot care
Routine school physicals or sports physicals
Smoking Cessation programs
Sterilization if under the age of 21
Supplies and equipment for personal comfort
Telephone consultation
Weight loss clinic programs

Service limits may be defined as including but not limited to a certain number of units or visits or within a certain cost.

APPENDIX 4 – Cost-Sharing Instructions

HEALTH INSURANCE PREMIUM PAYMENT HIPP for Kids (HFK) PROGRAM
Cost Sharing of Co-pays, Deductibles and Co-Insurance

HFK provides cost sharing to the Medicaid eligible member under age 19 and their parent when they are enrolled in a qualified employer-sponsored health plan and participating in HFK. Cost sharing payments are limited to items/services covered by both the qualified employer sponsored health plan and the State Plan for Medicaid.

Reimbursement of Cost Sharing
The policy holder MUST submit the Cost Sharing Medical Expense Form to request reimbursement. Medical claims information is evaluated on a quarterly basis. Please refer to the table below:

Medical Expense Period	*Verification Deadline	Reimbursement Month
January thru March	May 5th	June
April thru June	August 5th	September
July thru September	November 5th	December
October thru December	February 5th	March

***If the 5th is a weekend day or a holiday the next business day is the due date.**

In addition to submitting the Cost Sharing Medical Expense form below, the policy holder must submit:

- copies of itemized medical bills received from the medical provider showing the procedure/ CPT (the prescription drug name and the NDC number is required and must include the person who received the prescription);
- a copy of the Explanation of Benefits (EOB); and
- a copy of the canceled check, bank statement or receipt showing payment of the medical bill for each expense.

All prescriptions must be detailed on the Cost Sharing Medical Expense Record, one drug per line with the name of the drug in the "type of service field" or they will not be considered for reimbursement for that quarter.

Cost sharing payments are processed on the 17th of the Verification Deadline month. The check is mailed the last Friday of the following month. Expense documentation received after the 5th will not be processed.

Please note HFK only provides cost sharing for services covered by the health plan approved under the HFK program. **If the policy holder has a separate dental/vision plan for which HFK is not providing premium assistance, no cost sharing is permitted**. However, for the Medicaid eligible child, the servicing provider can bill Medicaid for potential cost sharing. Additionally, no payment is available for co-insurance/deductibles for services rendered by out of network providers for the employer sponsored group health plan.

The policy holder will be informed in writing of any requests for reimbursement that are denied. If all requested reimbursement is issued, no written notice will be sent.

Medicaid Eligible Members
Medicaid program providers must bill all other third-party insurance providers for items/services rendered for the Medicaid eligible member prior to billing Medicaid, as Medicaid is the payer of last resort. If the provider does not participate in the Medicaid program, the service may be eligible for cost sharing for the Medicaid eligible under age 19 when the service is also a Medicaid covered service.

Non-Medicaid Family Members (limited to parents only)
For expenses that meet program criteria, cost sharing for parents enrolled in the employer sponsored health plan is limited to the services covered by that plan and covered by the Medicaid State Plan.

Effective Date for Cost Sharing for Parents
Cost sharing for items and services rendered begins on or after the effective date of enrollment in the HIPP for Kids Program. Cost sharing will continue while there is active participation in the HIPP for Kids Program.

REV 08.2015

HFK Medical Expense Record 2016.doc [Compatibility Mode] - Word

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
COST SHARING MEDICAL EXPENSE RECORD – HFK PROGRAM

Name: _____ **Phone Contact Number:** _____

HIPP For Kids Case Number: _____ **HIPP for Kids Case** _____

Expense Period: _____

I understand, agree and certify that the information provided below is accurate and correct and that submission of documentation that has been altered or false information is cause for referral to the DMAS Recipient Audit Unit for review for fraud. Additionally, I understand that all decision on reimbursement are made in accordance with the policy and procedures governing the HFK Program.

COST SHARING MEDICAL EXPENSE RECORD:

NAME MEDICAID CHILD UNDER 19/PARENT WHO RECEIVED SERVICE	RELATIONSHIP TO EMPLOYEE	NAME OF SERVICES* PROVIDER	TYPE OF SERVICE RECEIVED	SERVICE DATE**		AMOUNT YOU PAID
				FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)	

HFK Medical Expense Record 2016.doc [Compatibility Mode] - Word

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					TOTAL THIS PAGE	$
					GRAND TOTAL FOR MULTIPLE PAGES	$

Participant's Signature:_____ **Date:**_____
(Required to process reimbursement)

* Provider of Services means hospital, doctor, dentist, drugstore, medical supply store, etc.
** Service date refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it

Please be advised that the preferred method for submission of documentation to the HIPP unit is by:

- Emailing scanned documents to the HIPPcustomerservice@dmas.virginia.gov, address; or
- Faxing documents to the HIPP fax # @ 804-452-5447.

3

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Appendix 5 -Sample EOB:

Blue Cross® Blue Shield®
Federal Employee Program

Anthem Blue Cross and Blue Shield
P.O. Box 27401
Richmond, Va. 23279-7401

1 of 1

ANTHEM BLUE CROSS AND BLUE SHIELD
P.O. BOX 27401
RICHMOND, VA 23279-7401
540-342-3492 TOLL FREE 1-800-552-6989
FOR THE DEAF (TDD): 1-800-662-6635
EMAIL ADDRESS - VAFEP@ANTHEM.COM
WEB ADDRESS - HTTP://WWW.FEPBLUE.ORG

30183

[redacted]

[redacted] 17

Explanation of Benefits
THIS IS NOT A BILL

EXPLANATION OF BENEFITS AT A GLANCE

We Sent Check To: [redacted]
Patient Name: [redacted]
Dates of Service: 12/03/2012 - 12/03/2012
You Owe the Provider: $10.00

ID Number: [redacted]
Claim Number:
Claim Paid On: 12/18/2012
Claim Received On: 12/07/2012
Claim Processed On: 12/12/2012
Patient Acct No: [redacted]

Provider: [redacted]
Type: PREFERRED PROVIDER

Dates of Service: 12/03/2012 - 12/03/2012

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
CONSULTATION	181.00	117.50	610		10.00		107.50	10.00
TOTALS:	181.00	117.50		0.00	10.00	0.00	107.50	10.00

EXPLANATION OF REMARK CODES

610--THE SUBMITTED CHARGES EXCEED OUR ALLOWABLE CHARGES FOR THESE SERVICES. OUR ALLOWABLE CHARGES ARE THE SUBMITTED CHARGES LESS ANY NON-COVERED CHARGES. BECAUSE THIS PROVIDER IS A PREFERRED OR PARTICIPATING NETWORK PROVIDER, YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE SUBMITTED CHARGES AND OUR ALLOWABLE CHARGES.

Summary of Out-of-Pocket Expenses for 2012

	Calendar Year Deductible	Catastrophic Protection Preferred	Catastrophic Protection Non-Preferred/ Preferred Total
What You Have Paid			
Individual	$0.00	$0	$0
Family	$0.00	$2,478	$0
Annual Maximum			
Individual	$0.00	$0	$0
Family	$0.00	$5,000	$0

Your Out-of-Pocket Expenses On This Claim	
Calendar Year Deductible	$0.00
Per Admission Copay	$0.00
Coinsurance	$0.00
Copayment	$10.00
Non-covered Charges	$0.00
Precertification Penalty	$0.00
TOTAL:	$10.00

If you have questions, please call a customer service representative at your local Blue Cross and Blue Shield Plan. You may also request the diagnosis codes, the treatment codes, and the corresponding meanings of the codes for your claim. If you disagree with the decision on your claims or request for services, and wish to have the decision reconsidered, you must notify your Plan in writing within 6 months from the date of this decision, i.e. 06/18/2013. You may request copies, free of charge, of any relevant materials and Plan documents relating to your claim. Your Plan will not accept unauthorized reconsiderations from providers. See the Disputed Claims section of your Service Benefit Plan Brochure.

NON-NEGOTIABLE

Appendix 6

CPT codes:

[redacted]

[redacted]

DETAILED PATIENT VISIT INVOICE

[redacted]

Encounter Date: 11/12/2012

Location: [redacted]

Patient's Employer at time of Visit:

CODE FOR ULCERA VISIT

Diagnosis Summary

Rank	Diagnosis Code	Description
1	556.0	ULCERATIVE (CHRONIC) ENTEROCOLITIS

Transaction Detail

Responsible	Rev?	Date	Code	Description	Examining Provider	Diag	Qty	Fee	Amount
COVA CARE - ANTHEM BCBS	N	11/12/2012	99213	OFFICE/OP VISIT, EST PT, 2 KEY	[redacted]	1	1	$95.00	$70.00
GUARANTOR	N	11/12/2012	COPAY	COPAY TRANSACTIONS	[redacted]	1	1		$25.00
	N	11/12/2012	PPCDO	CR. CARD OFFICE PMT PERSONA	[redacted]	1	1		-$25.00

Procedure Balance: $70.00

Balances for Visit

Guarantor	Insurance	Worker's Comp	Other	Collections	Total
0.00	70.00	0.00	0.00	0.00	70.00

Balances for Guarantor

Guarantor	Insurance	Worker's Comp	Other	Collections	Total
$0.00	$70.00	$0.00	$0.00	$0.00	70.00

Appendix 7- Itemized Bill:

COMMONWEALTH PRIMARY CARE, INC.

Tax ID #. 12/24/12 8:34 am

[redacted] 12/24/12 8:30 am [redacted]

[redacted]

Ins. Plan #1: Anthem BCBS
Group No: [redacted]
Policy No: [redacted]
Ins. Plan #2:
Group No:
Policy No:

Insurance Balance: $0.00
Patient Balance: $0.00

Visit Reason:
sick

Copay $25.00

OFFICE VISITS

99201	New Pt Brief	
99202	New Pt Limited	
99203	New Pt Intermediate	
99204	New Pt Extended	
99205	New Pt Comprehensive	
99211	Nurse Visit	
99212	Estab Pt Brief	
99213	Estab Pt Limited	
99214	Estab Pt Intermediate	
99215	Estab Pt Comprehensive	

PHYSICALS

99381	Prev New Pt Under 1 Yr	
99382	Prev New Patient 1-4 Yrs	
99383	Prev New Pt 5-11 Yrs	
99384	Prev New Pt 12-17 Yrs	
99385	Prev New Pt 18-39 Yrs	
99386	Prev New Pt 40-64 Yrs	
99387	Prev New Pt 65 & Older	
99391	Prev Estab Pt Under 1 Yr	
99392	Prev Estab Pt 1-4 Yrs	
99393	Prev Estab Pt 5-11 Yrs	
99394	Prev Estab Pt 12-17 Yrs	
99395	Prev Estab Pt 18-39 Yrs	
99396	Prev Estab Pt 40-64 Yrs	
99397	Prev Estab Pt 65 & Older	

MEDICARE PREV

G0101	Screening Breast/Pelvis	GA
G0102	Prostate CA Digital Rectal	GA
Q0091	Screening Pap	GA
G0402	Welcome to Medicare - PE	GA
G0403	Welcome to Medicare - EKG	GA

CONSULTS

99241	Consult/Pre-Op Focused
99242	Consult/Pre-Op Expanded
99243	Consult/Pre-Op Detailed
99244	Consult/Pre-Op Compreh
99245	Consult/Pre-Op Complex

Referring Physician:
DOA: WORK/AUTO/OTHER

PROCEDURES/SURGERY

93000	EKG	GA
93040	EKG Rhythm Strip	GA
94760	Pulse Oximetry	GA
94010	Spirometry	GA
94060	Spirometry (Pre/Post)	GA
94640	Nebulizer	GA
92560	Bekesy Audio. (screening)	GA
94664	Evaluate Pt use of Inhaler	GA
92561	Bekesy Audio. (diagnostic)	GA
69210	Cerumen Removal	GA 380.4
92567	Tympanometry	GA
99173	Vision Screen	GA

PROCEDURES/SURGERY (CONT'D)

92551	Pure Tone Hearing Test	GA
65205	Remove Foreign Body From Eye	GA
10120	Remove Foreign Body - Subcutaneous	GA
46600	Anoscopy	GA
17000	Destroy Benign Lesion 1	GA
17003	Ea Add'l (2-14)	
17004	Benign Lesions, 15+	GA
17110	Destruction, Warts <14	GA
10060	Incision & Drainage of Abscess	GA
10061	Incision & Drainage of Abscess, Multi	GA
20600	Joint Injection, Small	GA LT RT
20605	Joint Injection, Intermediate	GA LT RT
20610	Joint Injection, Major	GA LT RT
20550	Injection, Tendon Sheath	GA Lt. RT.
20552	Trigger Point Inject. Muscle 1 or 2	GA
11200	Removal, Skin Tags, up to 15	GA
11201	Removal, Skin Tags, Ea Add'l 10	
11750	Removal, Nail Bed	GA
11055	Paring Skin Lesion	GA
11100	Punch Biopsy Skin Lesion	GA
11300	Shave Skin Lesion/Trk, Ext (<0.5cm)	GA
12011	Repair Super, Facial (<2.6cm)	GA
12001	Repair Super, Scalp/Trk (<2.6cm)	GA
12002	Repair Super, Scalp/Trk (2.6cm-7.5 cm)	GA
	Modifiers 50 51 59	

INJECTIONS & IMMUNIZATIONS

90471	Admin of Immunization	GA	
90472	Admin of Ea. Add'l Vaccine	GA	
96372	Admin of Injection	GA	
J3420	VIT B-12	GA	
95115	Allergy Shot, Single	GA	
95117	Allergy Shot, 2 or More	GA	
J3301	Triamcinolone 10 MG	GA	
J2550	Phenergan, up to 50 MG	GA	
J0696	Rocephin 250 MG	GA	
J1885	Toradol 15 MG & 30 MG	GA	
J2175	Demerol per 100 MG	GA	
J1030	Depomedrol 40 MG	GA	
J3410	Vistaril 25 MG	GA	
J3120	Testosterone 100 MG	GA	
90748	Comvax	GA	V06.8
90649	HPV Vaccine	GA	V04.89
90669	Prevnar	GA	V06.8
90700	DTAP under 7 Yrs	GA	V06.1
90702	DT under 7 Yrs	GA	V06.5
90715	TDAP 7 Yrs +	GA	V06.5
90718	TD (Tetanus) 7 Yrs +	GA	V06.5
90645	HIB	GA	V03.81
90733	Meningococcal, Subcutaneous	GA	V05.8
90734	Meningococcal Tetravalent, IM	GA	V05.8
90707	MMR	GA	V06.4
90713	Polio	GA	V04.0
90720	DTP-HIB	GA	V03.81

INJECTIONS & IMMUNIZATIONS (CONT'D)

90716	Varicella	GA	V05.4
90632	Hep A - Adult	GA	V05.3
90633	Hep A (6-14 Yrs)	GA	V05.3
90744	Hep B (0-19 Yrs)	GA	V05.3
90746	Hep B (>20 Yrs)	GA	V05.3
86580	TB Test	GA	V74.1
90658	Influenza	GA	V04.81
G0008	Medicare Admin Fee-Flu	GA	V04.81
90732	Pneumococcal	GA	V03.82
G0009	Medicare Admin Fee-Pneu	GA	V03.82

XRAYS

71010	Chest, 1 View	GA
71020	Chest, 2 Views	GA
77080	Dexascan	GA
73080	Elbow	GA LT RT
73550	Femur	GA LT RT
73140	Finger(s)	GA
73630	Foot	GA LT RT
73090	Forearm	GA LT RT
73130	Hand	GA LT RT
73650	Heel	GA LT RT
73510	Hip	GA LT RT
73560	Knee 1-2 Views	GA LT RT
73562	Knee 3 Views	GA LT RT
71101	Ribs	GA LT RT
72220	Sacrum/Coccyx	GA
73030	Shoulder	GA LT RT
70210	Sinuses 1-2 Views	GA
70220	Sinuses 3+ Views	GA
72100	Spine L/S 2-3 Views	GA
72110	Spine L/S 4+ Views	GA
72070	Thoracic Spine	GA
72040	Neck 2 or 3 Views	GA
72050	Spine, Cervical 4+ Views	GA
73590	Tib/Fib	GA LT RT
73660	Toe (s)	GA
73110	Wrist	GA LT RT
73610	Ankle	GA LT RT
72170	Pelvis	GA
74000	Abdomen	GA
74022	Flat and Upright Ab. w/Chest	GA

OTHER

After Hours Fees
No Show Fee 25 50 100
Void Ticket
No Charge
99070 Supplies

Physician's Signature:

NOTES

G8443 ALL (1) 784.0 Va Cancel
G8445 NONE (2) 796.2 carotid duplex
G8446 PART (3) 787.02
(4) 433.10

REFERRING PHYSCIAN

D.O.A. ☐ WORK ☐ AUTO ☐ OTHER

ACCIDENT DATE

01 JAN 02 FEB 03 MAR 04 APR 05 MAY 06 JUN 07 JUL 08 AUG 09 SEP 10 OCT 11 NOV 12 DEC

10 98 20 99 30 00 10 01 2 02 3 03 4 04 5 05 6 06 7 07 8 08 9 09

E WORK A AUTO O OTHER

METHOD

CASH ☐ CHECK ☐ CHARGE

COPAYMENT

25.00

#25.00 COPAYMENT

Virginia Administrative Code
Title 12. Health
Agency 30. Department of Medical Assistance Services
Chapter 20. Administration of Medical Assistance Services

12VAC30-20-205. Health Insurance Premium Payment (Hipp) for Kids.

E. Exceptions. The term "qualified employer-sponsored coverage" does not include coverage Consisting of:

1. Benefits provided under a health flexible spending arrangement (as defined in § 106(c)(2) of the Internal Revenue Code of 1986) or

2. A high deductible health plan (as defined in § 223(c)(2) of the Internal Revenue Code of 1986), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of the Internal Revenue Code of 1986).

3. For self-employed individuals, qualified employer-sponsored coverage obtained through self-employment activities shall not meet the program requirements unless the self-employment activities are the family's primary source of income and the insurance meets the requirements of the definition of qualified employer-sponsored coverage in subsection A of this section. Family for this purpose includes family by blood, marriage, or adoption.