

Chapter 6

Claims Processing

This chapter covers the claims processing procedures pertaining to the Health Care Responsibility Act (HCRA). The claims processing and fiscal reporting procedures described in this handbook are the minimum standards that will be applied in each participating county in the state. These procedures and related reports may need to be adapted and modified by certain counties due to differences in claim volume and administrative systems. This chapter is divided into four parts: Time Standards, Hospital Responsibilities in Processing Claims, County Responsibilities in Processing Claims, and State Comptroller Responsibilities.

Time Standards

6-1 Hospital Claims Processing Time Standards: The hospital has six months from the date of the Notification of Eligibility, approving an applicant's eligibility, to submit a completed UB-04 claim for payment to the appropriate county claims processing agent. The county may accept or deny any claim submitted after the six months submission time period.

- A. The hospital must submit a copy of the patient's Notification of Eligibility, with the completed UB-04 claim form to the county billing agent. Reimbursement for service provided should be paid at the rate authorized at the time of service. If a hospital has been granted a revised/interim per diem rate by Medicaid, official notification of this change in per diem must be submitted with the claim in order for the county to pay the claim at the new rate.
- B. Claims may be submitted individually or in batches, depending on the hospital's claim volume.
- C. If an administrative hearing has delayed the submission of a claim, the hospital has 30 days from the date of the final order approving reimbursement to submit such a claim to a county.

6-2 Resubmitting a Denied Claim: The hospital may resubmit a claim denied by a county due to its missing information in the fields on the UB-04 listed as mandatory in Section 6-11. However, the corrected claim must be resubmitted within six months of the date of the Notification of Eligibility.

6-3 County Claims Processing Time Standards: The county has 90 days from the date it receives the claim to complete its adjudication and transmit its reimbursement, if appropriate, to the hospital. This excludes any claim being contested under an administrative hearing. The county should date stamp or otherwise mark "received" on the claim form to verify the receipt date. It is on this date that the 90-day time period for claims processing begins.

6-4 Hospital's Course of Action if Claims Processing Exceeds Time Standards: If the hospital is not notified by the county of the disposition of a claim within the required 90 days, the hospital should contact the county billing agent and request the status of the claim and attempt to resolve any issues delaying its adjudication.

- A. If there are no issues and the hospital has not received payment within the 90 day deadline, then the hospital may request that the State Comptroller's office reimburse the hospital directly from any funds owed the county.
- B. If the issues cannot be resolved by the county and the hospital, the hospital may request a county level hearing or administrative appeal. The hospital may also contact the Agency for technical assistance at the address or telephone number provided in Chapter 1, Section 1-11.
 - 1. The appeal process is discussed in Chapter 7.
 - 2. If the claim is disputed and payment is not received from the county determined to be responsible within 60 days after all legal and administrative remedies have been exhausted, then the hospital may request that the State Comptroller's office reimburse the hospital directly from any funds owed to the county.

Hospital Responsibilities for Claims Submission and Processing

6-5 Basis Rules for Claim Preparation: The hospital is responsible for preparing the UB-04 claim form for each HCRA applicant for which it has received a Notification of Eligibility from the certifying agency indicating the applicant is eligible. Hospitals may not submit claims for payment prior to the receipt of the Notification of Eligibility.

The hospital must complete the claim form in the following manner:

- A. Always use the UB-04 claim form.
- B. Be sure the information on the UB-04 form is legible.
- C. Enter all information with a typewriter or print with a black pen.
- D. Determine if there is any third party insurance or other payor coverage that would affect an applicant's eligibility or amount of reimbursement. See Third Party Coverage, Section 6-6, for more information on payment involving third party payors.
- E. Prepare, if inpatient services were provided, an inpatient claim.
 - 1. The hospital must use one claim form for each inpatient stay.

2. The hospital should refer to Appendix H for step-by- step instructions for completing the UB-04 inpatient claim and also for an example of a properly completed inpatient claim.

F. Prepare, if outpatient services only were provided, an outpatient claim.

1. The hospital must use one claim form for each outpatient date-of-service.
2. The hospital should refer to Appendix H for instructions that identify those outpatient fields on the UB-04 that are either not required or are completed differently from an inpatient claim.

G. Complete the UB-04 claim form fully and accurately.

1. If the hospital submits an incomplete or inaccurate claim form, the county may deny the claim.
2. The hospital should review the claim once it has been completed to assure that the mandatory items identified in the Section 6-11, In-Depth Review of UB-04 Claim Form, are completed.

6-6 Third Party Coverage: The hospital must determine the existence of private insurance or other coverage for a patient prior to submission of a claim, because third party coverage may affect an applicant's eligibility.

- A. If there is third party coverage, the county will make payment under this program only if the third party coverage is less than 80 percent of the hospital's per diem rate or less than the written reimbursement rate agreed upon by the county and the hospital.
- B. There may be joint payment on a claim by both this program and such third party coverage (as indicated in item a. above) provided the combined total payment does not exceed 100 percent of the Medicaid per diem rate. For information on calculating the amount of HCRA reimbursement allowed when combined with third party coverage, see Section 6-20.
- C. The hospital must pursue other insurance or other coverage until such payment is received before submitting a claim to the county billing agent for reimbursement.
- D. The hospital must identify the actual amount of reimbursement received from the other coverage in claim FIELD 50. The hospital must prepare the UB-04 showing other coverage as indicated in Appendix H.

- E. If payment from other insurance or other coverage has been delayed and the hospital is concerned about the six months submission time frame, the hospital should submit a claim to the county billing agent and identify the estimated amount of reimbursement expected from the other insurance or other coverage in claim FIELD 50. The hospital is responsible, however, for notifying the county of any change in the actual amount of third party reimbursement received.
- F. If or when the hospital receives reimbursement from a third party or any other source, it is the hospital's responsibility to refund any amount paid by the county as outlined in Section 6-9.

6-7 HCRA Payment as Payment in Full: If an applicant's claim is adjudicated as payable, the payment made to the hospital is considered as payment in full, except for non-covered services and for the spend-down provision applicant's share of cost.

6-8 Collecting the Applicant's Share of Cost: If the applicant is a spend-down provision applicant and the county adjudicates the applicant's claim as payable, then the county will reduce the hospital's reimbursement by the amount of the applicant's share of cost before making payment. The applicant's share of cost will be indicated by the county on the applicant's Notification of Eligibility. The hospital may bill the applicant for the applicant's share of cost and the cost of other non-HCRA-covered services.

6-9 Refunding HCRA Payments to the County: If, after a county has paid a claim, the hospital receives payment from a third party (including Medicaid) for the same hospital services, the hospital must refund the HCRA funds to the county within 30 days of receipt of such payment. The refund is made as follows:

- A. If the third party payment received was from a governmental reimbursement program, such as Medicaid, Medicare, or Worker's Compensation, the hospital must refund the entire HCRA payment to the county. This is because the applicant's eligibility for another governmental hospital reimbursement program makes him ineligible for HCRA.
- B. If the third party payment was from a non-governmental entity (such as an insurance company or a payment as a result of a law suit), and such payment was not listed on the UB-04, the hospital must compare the third party payment received to 80 percent of the Medicaid per diem rate, or other negotiated rate.
 - 1. If the third party payment received was equal to or greater than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund the full HCRA payment to the county.

- a. For example: The county paid the hospital \$500 through HCRA, a third party paid the hospital \$400 for the same inpatient day of covered service, and the Medicaid per diem rate was \$500 (no other reimbursement rate was negotiated).

A full refund is required because the \$400 paid by the third party is equal to 80 percent of the Medicaid per diem rate. Therefore, the third party payment is considered adequate third party insurance, as defined in Appendix A and in rule, and the hospital must refund the full \$500 to the county.

2. If the third party payment received was less than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund to the county the difference between the combined reimbursement received (county and third party) and 100 percent of the Medicaid rate.

- a. For example: The county paid the hospital \$500 through HCRA, a third party paid the hospital \$300 for the same inpatient day of covered service, and the Medicaid per diem rate was \$500. The county is only obligated to have paid the hospital \$200; therefore, the hospital must repay the county \$300 as indicated in the following calculation.

$$\begin{aligned} & \$800 \text{ (Combined HCRA County and Third Party Payor Reimbursement)} \\ & - \$500 \text{ (100\% of Medicaid Per Diem Rate)} \\ & = \$300 \text{ (Amount Hospital Refunds to the County)} \end{aligned}$$

- C. If the third party payment was from a non-governmental entity, and was under-estimated on the UB-04, the hospital must determine if the payment received was equal to or more than 80 percent of the Medicaid per diem rate or other negotiated rate, if there was another reimbursement rate negotiated.
 1. If the third party payment was equal to or greater than 80 percent of the Medicaid per diem rate or other negotiated rate, the hospital must refund the full HCRA payment to the county.
 2. If the third party payment received was less than 80 percent of the Medicaid per diem rate, the hospital must repay to the county the difference between the estimated insurance indicated on the UB-04 claim form submitted to the county and the actual payment received.

County Responsibilities for Claims Processing

6-10 County's Review of Claim and Hospital Notification: The county billing agent must review the claim to verify that the appropriate Notification of Eligibility is attached to each claim and that the claim form was submitted within the required time frame.

- A. If the Notification is not attached, deny the claim and return it to the hospital with a statement that it was denied because the Notification was not attached.

- B. If the Notification is attached, verify that the claim form was submitted (postmark date) within six months of the notification of eligibility. Also compare the claim information with that of the Notification in order to confirm the eligibility status of the patient, the date(s) of hospital service provided, and the name of the hospital providing service.
 1. If the claim was mailed to the county more than six months after the date of the Notification, the county may deny the claim. If the postmark date of the claim is within the six months after the date of the Notification, then proceed with comparing the Notification information to the information provided on the applicant's claim form.
 2. If the information on the Notification conflicts with the claim, deny the claim and return it to the hospital with a statement of why it is denied.
 3. If the information is consistent with the claim, proceed with the review.
 4. If the hospital resubmits a completed claim form and Notification within the six months' time frame, the county must continue with the claims reimbursement process.

6-11 In-Depth Review of UB-04 Claim Form: The county billing agent must review the claim form in accordance with the instructions in this chapter. The county must review the claim form to ensure that the following fields on the UB-04 claim form are complete. The completion of these fields is MANDATORY. The claim example in Appendix H identifies the location of these fields.

Provider Name and Address	Field 01
Financial Classification Code	Field 02
Type of Bill	Field 04
From-Thru Dates	Field 06
Patient Name	Field 12
Patient Birthdate	Field 14
Admission Date (Inpatient Only)	Field 17
Type of Admission (Inpatient Only)	Field 19
Source of Admission	Field 20
Discharge Hour	Field 21
Patient Status (Inpatient Only)	Field 22
Condition Code	Fields 24-30
Occurrence Code and Date	Fields 32-35 A and B
Revenue Code	Field 42

Revenue Description	Field 43
Service Units	Field 46
Total Charges	Field 47
Payer Identification (Inpatient Only)	Field 50
Principal Diagnosis	Field 67
APR-DRG Code (Inpatient Only)	Field 71
Provider Representative Signature	Field 85
Date Bill Submitted	Field 86

- A. If one or more of these fields are incomplete or omitted, the claim may be adjudicated as denied. However, the county may obtain the missing information from the hospital by telephone and thereby avoid the possible denial of the claim.
- B. If the hospital resubmits a completed claim form and Notification within the six-month time frame, the county must continue with the claims reimbursement process.
- C. For Fields 42 and 43, inpatient and outpatient revenue center codes and descriptions are identified in Section 6-13.
- D. Field 50 is mandatory only if there is insurance (other payor) coverage.

6-12 Review of Field 19: Inpatient Care/Emergency Care: Inpatient care under this program is primarily provided for the purpose of treatment for emergency conditions. Therefore, the claim must identify the type of admission in FIELD 19.

- A. The code '1' in this field indicates that the patient was admitted under an emergency situation.
- B. A claim may be denied for a code other than '1' in this field, unless the county and the hospital have an agreement to provide non-emergency treatment under the program. The county billing agent should be notified of such agreements. See Section 3-5 for further information regarding such agreements.

6-13 Adjudication of Claims by the County: Once the claim and Notification have been reviewed, a decision of adjudication can be made as to whether the claim is denied or approved for payment.

- A. The county billing agent should review Chapter 3, Covered Services, to become familiar with the days of care covered by HCRA, the hospital services covered by HCRA, and the outpatient reimbursement limits.

Inpatient Revenue Center Codes are covered in Appendix A of the Florida Medicaid Hospital Services Coverage and Limitations Handbook, which is available on the

Medicaid fiscal agent's website at <http://mymedicaid-florida.com>. Click on Provider Services, Support, Handbooks.

Appendix B of the Florida Medicaid Hospital Services Coverage and Limitations Handbook has the list of revenue center codes exclusively for outpatient hospital billing. For each different outpatient revenue code, HCRA will pay the outpatient rate one time per day regardless of the charges or the number of units billed. Exceptions to the rate payment are outpatient laboratory and pathology revenue center codes. Those require a five-digit HCPCS procedure code in Form Locator 44 on the UB-04 claim form. The outpatient lab codes are on the Florida Medicaid Provider Reimbursement Schedule, which is available on the Medicaid fiscal agent's website at <http://mymedicaid-florida.com>. Click on Provider Services, Support, Fee Schedules, Independent Laboratory.

- B. Reimbursement may not exceed 45 inpatient days of service per county fiscal year through both HCRA and the Shared County and State Health Care Program (SCS), if the SCS program is funded.
- C. The county must review UB-04 FIELDS 24-30 and FIELD 50 to determine if there is insurance (other payor) coverage.
 - 1. If there is third party coverage, the county may make payment under this program only if the third party coverage is less than 80 percent of the hospital's per diem rate, or less than the written reimbursement rate agreed upon by the county and the hospital if the agreed upon rate is greater than 80 percent of the Medicaid per diem rate.
 - 2. There may be joint payment on a claim by both this program and such third party insurance (as indicated in item a. above) provided the combined total payment does not exceed 100 percent of the Medicaid per diem rate. For more information on calculating reimbursement with third party insurance, see Section 6-20.

6-14 Determining the Amount of Reimbursement for Inpatient Claims for Counties at Their 10 Mill Cap on Ad Valorem Taxes: Counties at their 10 mill cap on ad valorem taxes as of October 1, 1991, reimburse hospitals for inpatient care at a rate equal to 80 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed upon. If an inpatient claim is approved for payment, the actual payment is based on the four-digit APR-DRG code.

6-15 Determining the Amount of Reimbursement for Inpatient Claims for Counties Not at Their 10 Mill on Ad Valorem Taxes: Counties NOT at their 10 mill cap on ad valorem taxes as of October 1, 1991, reimburse hospitals for inpatient care at a rate equal to 100 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed

upon. The county billing agent determines the amount of reimbursement for inpatient claims by first determining if the claim is for a spend-down provision applicant.

- A. The county billing agent determines if the claim is for a spend-down provision applicant by reviewing the applicant's Notification of Eligibility. The county certifying agency will have indicated on the Notification if the applicant is a spend-down provision applicant.
- B. If the Notification indicates that the applicant is NOT a spend-down provision applicant, then the payment is based on the four-digit APR-DRG code.
- C. If the Notification indicates that the applicant is a spend-down provision applicant, then the county determines the amount of payment as indicated below.

6-16 Determining the Amount of Reimbursement for Inpatient Claims for Spend-Down

Provision Applicants: For the spend-down provision applicant, claims payment for an inpatient claim is handled differently than for any other type of HCRA applicant. To determine the amount of payment for an inpatient claim for such an applicant, the county billing agent uses the following procedures:

- A. The county must first determine the amount of reimbursement for which the applicant would have been eligible if he was not a spend-down provision applicant. The county billing agent, therefore, determines reimbursement to the hospitals for inpatient care at a rate equal to 100 percent of the hospital's Medicaid rate per the DRG Pricing Calculator, unless another rate has been agreed upon.
- B. Deduct from the above figure the applicant's share of cost as indicated on the Notification of Eligibility. The remainder is the amount of payment to be made to the hospital.
 - 1. If the share of cost exceeds the reimbursement amount determined in item a. above, then the applicant is not eligible for HCRA and the claim must be denied.
 - 2. If the applicant has already met his share of cost by being financially responsible for a previous hospital stay which would have been HCRA eligible, then no deduction is made. Such a stay must have occurred within the 4 weeks prior to the date of admission/service indicated on the applicant's Notification of Eligibility.
 - 3. On whichever day the applicant has met his share of cost, he becomes eligible for HCRA reimbursement for the remainder of that day. All remaining days are paid at 100 percent of the Medicaid per diem rate or other negotiated rate.

6-17 Examples of Reimbursements to Hospitals for Spend-Down Provision Applicants: The following are examples of reimbursements to hospitals for spend-down provision eligible applicants:

- A. Example 1: Bob's share of cost is \$372. He has one covered day of service. The Medicaid reimbursement is calculated at \$500. The total HCRA reimbursement to Bob's hospital is \$128.

\$500 (1 day at the Medicaid per diem rate)
- 372 (share of cost)
\$128 (total HCRA reimbursement)

- B. Example 2: Sam's share of cost is \$572. He has two covered days of service. The Medicaid reimbursement is calculated at \$1,000. The total HCRA reimbursement to Sam's hospital is \$428:

\$1,000 (2 days based on the APR-DRG code)
- 572 (share of cost)
\$ 428 (total HCRA reimbursement)

- C. Example 3: Joan's share of cost is \$594. She has only 1 day of covered service. The Medicaid reimbursement is calculated at \$500. Joan is not eligible for HCRA reimbursement because she has not met her share of cost:

\$500 (1 day at the Medicaid per diem rate)
-594 (share of cost)
\$-94 (unmet share of cost)

- D. Example 4: Joan is admitted again to the out-of-county hospital (two weeks after her first admission) for services related to the first episode of care. These services are not of an emergency nature; however, the services are unavailable in Joan's county of residence and her county has "prior approved" her HCRA application provided she meets her share of cost. Joan is hospitalized for three days (two days of covered service). The Medicaid reimbursement is calculated at \$1,000.

Because the second admission occurs within 4 weeks of the discharge date of Joan's admission and it is related to the first episode of care, Joan has already met \$500 of her share of cost in her first episode of care. Therefore, Joan needs only to meet \$94 in her second episode of care in order to have the remainder of her second bill paid through HCRA.

\$1,000 (2 days based on APR-DRG code)
- 94 (unmet share of cost)
\$ 906 (total HCRA reimbursement)

6-18 Determining the Amount of Reimbursement for Outpatient Claims for Non-Spend-Down Provision Applicants:

If an outpatient claim is approved for payment, the actual payment is based on the revenue center codes listed in Field 42 on the claim, the Medicaid rate or agreed upon reimbursement rate, and any lab/pathology procedure code fees (outpatient revenue center codes 300 through 319).

- A. The actual payment must take into consideration the \$1,500 cap limitation described in Covered Services, Chapter 3, Sections 3-16 and 3-17.
- B. Each unique outpatient revenue center the claim, excluding codes 300 code identified on through 319, is reimbursable at 100 percent of the Medicaid outpatient line item rate or other negotiated rate. A listing of reimbursable outpatient revenue center codes is provided in Section 6-13.
- C. For each outpatient revenue center code 300 through 319 (laboratory/pathology codes) listed in FIELD 42, there must be a corresponding description in FIELD 43 and a corresponding five digit procedure code in FIELD 44. Each of these procedure codes has its own maximum reimbursement amount (as indicated in Section 2-11 and Section 6-13).
- D. Reimbursement is limited to each unique revenue center code. However, for revenue center codes 300-319 (laboratory and pathology codes), payment is made for each unique laboratory/pathology procedure code identified on the claim. No payment may be made for duplicate listings of the same codes.
- E. The total payment to the hospital is the sum of the payments for each unique revenue center code and each unique laboratory/pathology procedure code.
- F. For example, an outpatient claim indicates the following in FIELDS 42, 43, and 44.

42 Revenue Code	43 Description	44 HCPCS/Rates
250	Pharmacy	
300	Laboratory	87118
300	Laboratory	87068
450	Emergency Room	

The hospital's outpatient line item reimbursement rate is \$50.00. All revenue codes are reimbursable (see Section 6-13). Codes 250 and 450 are unique; therefore, payment for these two codes is \$100.00 (\$50 X 2). Code 300 indicates laboratory codes. Therefore, to determine payment for this code, FIELD 44 must be reviewed. Each code 300 has a unique procedure code (87118 and 87086) and each is reimbursable. These code numbers must be reviewed against the most recent Laboratory and Pathology fee listing (see Section 6-13). The maximum fee listed payable by Medicaid for Code 87118 is \$8.50.

The maximum fee for Code 87086 is \$6.00. Unless the county has a written agreement to pay an amount other than the maximum allowed by Medicaid, the amount the county must pay for these codes is \$14.50 (\$8.50 and \$6.00). Therefore, the total payment made by the county to the hospital is \$114.50.

6-19 Determining the Amount of Reimbursement for Outpatient Claims for Spend-Down

Provision Applicants: Like inpatient claims payment, outpatient claims payment for the spend-down provision applicant is handled differently than for any other type of HCRA applicant. To determine the amount of payment for the spend-down provision applicant's outpatient claim, the county billing agent uses the following procedures:

- A. The county must first determine the amount of reimbursement for which the applicant would have been eligible if he was not a spend-down provision applicant by using the procedures indicated in Section 6-18. This would be the sum of the payments for each unique revenue center code and each unique laboratory/pathology procedure code.
- B. Deduct from the above figure the applicant's share of cost as indicated on the Notification of Eligibility. The remainder is the amount of payment to be made to the hospital.
 1. If the share of cost exceeds the amount determined in item a. above, then the applicant is not eligible for HCRA and the claim should be denied.
 2. If the applicant has already met his share of cost by a previous hospital stay which would have been HCRA eligible, then no deduction is made. Such a stay must have occurred within 4 weeks of the date of admission/service indicated on the applicant's Notification of Eligibility.

6-20 Calculating Reimbursement with Third Party Insurance: If a claim has been adjudicated as payable, and also identifies an amount paid by other insurance, the reimbursement amount is calculated as follows:

- A. Use the hospital's full (100%) Medicaid per diem rate (even if the county is using a per diem rate that is less than the Medicaid rate). The use of the full Medicaid per diem is intended to be an incentive for the hospital to pursue all possible insurance coverage.
- B. Multiply this per diem by the number of approved days.
 1. If this amount is less than or equal to the insurance amount identified on the claim, no payment under this program is allowed.
 2. If this amount is greater than the insurance amount identified on the claim, the difference between the two amounts is the total reimbursement allowed under this program. If the applicant is a spend-down provision applicant, the total

reimbursement allowed is the difference between the amount in item b. and the sum of the insurance amount and the applicant's share of cost.

6-21 No Retroactive Per Diem Rate Adjustments: Reimbursement for service provided should be paid at the rate authorized at the time of service. Therefore, if a hospital has been granted a revised/interim per diem rate by Medicaid, the hospital must notify the county of this change in per diem, in order for the county to reimburse the hospital at the new rate.

- A. Medicaid per diem rates are updated and distributed by the Agency to each county billing agent in July of each year.
- B. If a Medicaid rate is not available for a hospital, the county billing agent should contact the Agency's Bureau of Central Services.
- C. The per diem rate utilized at the time of claim adjudication is considered the final rate for that claim. No retroactive per diem rate adjustment is allowed.

6-22 Transmitting Reimbursement to the Hospital: Once the total amount of payment has been identified for a claim or a group of claims, this information is submitted to the appropriate county financial office to prepare and transmit a reimbursement check to the hospital.

- A. The county billing agent must attach to each reimbursement check a report listing specific information on the adjudicated claims covered in the reimbursement check.
- B. The county billing agent must report the following information to the hospital on each paid claim:
 - 1. Patient's name;
 - 2. Patient's Social Security number, if known;
 - 3. Date of admission;
 - 4. Actual paid days (days paid by the program); and
 - 5. Amount paid.
- C. The suggested form to be used for this supporting information is found in Appendix I.

6-23 Denied Claims: The county must notify the hospital on those occasions when a claim is denied. A report on denied claims must be provided to the hospital indicating the reason for denial. The county billing agent must report the following information:

- A. Patient's name;
- B. Patient's Social Security number, if known;
- C. Date of admission;
- D. Indication that the amount paid is zero; and
- E. A brief reason as to why the claim was denied.

The county must also include on the report a statement informing the hospital of its right to request an administrative hearing on any of the claims denied.

6-24 Failure to Provide Payment: If the responsible county does not pay the hospital for an eligible applicant within 90 days of receipt of a claim, or if the claim is disputed and payment is not received from the county within 60 days after all legal and administrative remedies have been exhausted, the hospital may seek payment from state funds due the county through the State Comptroller's office as indicated below.

State Comptroller Responsibilities

6-25 Hospital's Certification for Payment to the State Comptroller's Office: If the county fails to provide payment within the time frames indicated above, the hospital may request payment from the State Comptroller's office by submitting the following information to the Comptroller:

- A. A certification of the name of the patient, the patient's identification number, the documented date that the claim was received by the county, and the amount of the claim;
- B. A copy of the claim that was submitted to the county;
- C. A copy of the Notification of Eligibility;
- D. A copy of the final order (for disputed claims);
- E. Documentation, if applicable, that the county of residence was at its 10 mill cap on ad valorem taxes as of October 1, 1991;
- F. Any other documentation the Comptroller might require that would support payment of the claim.

The hospital must submit this information to:

Department of Financial Services
Accounting and Auditing
200 East Gaines Street
Tallahassee, Florida 32399-0318

If, after the State Comptroller has paid a claim, the hospital receives payment from a third party (including Medicaid) for the same hospital services, the hospital **must refund the payment to the State Comptroller within 30 calendar days of receipt of such payment from the third party.**

6-26 State Comptroller Responsibilities: The State Comptroller pays such claims to the hospital, provided the hospital has submitted all of the documentation listed in 6-25 above.

- A. The Comptroller reimburses hospitals for eligible indigent patients from any funds due to the county under any revenue-sharing fund established by the state, except as otherwise provided by the state constitution.
- B. The Comptroller will forward the amount delinquent to the hospital within 45 days of the date of receiving the hospital's certified notice.
 - 1. The Comptroller will reimburse hospitals at a rate not less than 100 percent of the hospital's Medicaid per diem rate.
 - 2. If the hospital or county provides the Comptroller with documentation that the county was at its 10 mill cap on ad valorem taxes as of October 1, 1991, then the Comptroller will reimburse the hospital at a rate not less than 80 percent of the hospital's Medicaid per diem rate.
 - 3. If the hospital or county provides the Comptroller evidence of a different negotiated rate or if the order of a hearing officer indicates a different rate of reimbursement, then the Comptroller will reimburse the hospital at the negotiated or court ordered rate.