Beyond Ortho Coding, LLC

NEWSLETTER

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Pennsylvania Medical Assistance- A brief summary relating to provider reimbursement

What is the difference between standard Medical Assistance (MA) and General Assistance (GA)?

The Pennsylvania Assistance Office uses specific qualifications to determine if a person is eligible for state covered benefits. When qualifications are met a beneficiary could be enrolled in either straight medicaid or a general assistance benefit plan. In biller terms, "straight medicaid" simply means the patient has **medical** insurance coverage benefits only, which then these benefits will fall under Medical Assistance (MA). However, if a beneficiary is determined to be medically needy & meet specific financial qualifications, then the benefits could fall under the classification of General Assistance (GA) benefits. GA benefits have both medical coverage & cash assistance benefits.

How does MA or GA benefit plans affect provider reimbursement?

Let's be honest, this fee schedule is what it is.[1] There are no *insurance* reimbursement differences between these two plans. However, the area that is affected is the patient copay liability.

Below is the benefit breakdown of copay allowance:

Medical Assistance Fee Schedule Allowance	Patient Copay Amount: **MA**	Patient Copay Amount: **GA**
$0 - $1.99	$0	$0
$2 - $10.00	$0.65	$1.30
$10.01 - $25.00	$1.30	$2.60
$25.01 - $50.00	$2.55	$5.10
$50.01 - and higher	$3.80	$7.60

Provider Reimbursement Comparison Example: Inpatient Total Knee Arthroplasty (TKA) with ***GA*** benefits. Medical assistance fee schedule allowance is $1000.00 with POS 21.

	27447		1000.00	21	Details **Procedure Description:** ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND LATERAL COMPARTMENTS WITH OR WITHOUT PATELLA RESURFACING (TOTAL KNEE ARTHROPLASTY)

In this example, if provider office staff collected the ***MA*** allowance instead of the proper ***GA*** allowance (collecting $3.80 instead of $7.60) then only 50% of the correct copay amount would have been collected. The remaining 50% *could* be collected at a later time but this could prove more costly to the practice's bottom line in the long run.

Best practice recommendations:

1) Verify patient eligibility along with the specific type of medical assistance benefits (MA vs GA)
2) Collect all applicable copays at TOS. This may include x-rays, E/M, & minor procedures,
3) Educate beneficiaries that multiple copays could apply to all services.

Editor's note: Multiple procedure payment reduction rules apply in a variation of scenarios- but that's another story for another time. For more information on how this affects copays or provider reimbursement, please visit **Beyondorthocoding.com** for contact info to discuss your practice's specific concern.

[1]Medical Assistance Choice Plans are separate contracts & different fee schedules. Please refer to individual contract information for copay and/or fee schedule information for those specific plans.