Services While Confined/Incarcerated

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Instructions for Use

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Related Policies
None

Coverage Guidelines

Services provided in a correctional facility or prisons are not covered by UnitedHealthcare Medicare or original Medicare in most circumstances.

Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
- The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

Refer to the CFR Title 42, Chapter IV, § 411.4 (b) – Special conditions for services furnished to individuals in custody of penal authorities. (Accessed November 12, 2020)

Notes:

- The CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services unless the state can demonstrate to the A/B MAC, (A)'s, (B)'s, or (HHH)'s , or DME MAC's satisfaction, in consultation with the RO, that:
  - State or local law requires that individuals in custody repay the cost of the services.
  - The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.
  - The A/B MAC (A), (B), or (HHH), or DME MAC will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources.
  - The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, the A/B MAC (A), (B), or (HHH), or DME MAC will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.
  - The CMS maintains a file of incarcerated beneficiaries, obtained from SSA, that is used to edit claims.

- Providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above indicate this fact with the use of a modifier (A/B MAC (B) processed claims) or condition code (for A/B MAC (A) processed claims). Otherwise the claims are denied.
  Refer to the CFR Title 42, Chapter IV, § 411.4 (b) – Special conditions for services furnished to individuals in custody of penal authorities. (Accessed November 12, 2020)

Payment may be made to the following two (2) categories of governmental providers even though they furnish services free of charge:

- Payment may be made for items and services furnished in or by a participating state or local government hospital, including a psychiatric or tuberculosis hospital which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be serving the general community if state law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in or by State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals.
- Payment may be made for items and services paid for by a state or local governmental entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent.

Refer to the Medicare Benefit Policy, Chapter 16, §50.3.1 – Application of Exclusion to State and Local Government Providers. (Accessed November 12, 2020)

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update • Reformatted policy; transferred content to new template
11/17/2020	• Routine review; no change to coverage guidelines

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).