MA-2360 MEDICAID DEDUCTIBLE
REVISED 11/01/07 - CHANGE NOTICE 25-07

I. POLICY RULE

An M-AABD Medically Needy (M) a/r whose net countable income exceeds Medically Needy Income Limit must meet a deductible before he may be authorized for Medicaid. The deductible is met by incurring medical expenses equal to the amount of the deductible.

The policy in this section may not be used to find a client eligible in MAABD Categorically Needy - No Money Payment (N) Classification, MQB (Q, B, or E), or MWD. Deductible does not apply in these coverages.

II. COMPUTING A DEDUCTIBLE

A. Monthly Excess Income

Refer to MA-2260, Financial Eligibility Regulations-PLA, and MA-2250, Income, for instructions on computing monthly excess income.

B. Calculating the Deductible

Calculate the deductible for the certification period.

1. Multiply

   a. The excess monthly income for Medically Needy (Refer to MA-2260, Financial Eligibility Regulations-PLA)

      by

   b. The number of months in the certification period. (Refer to MA-2350, Certification and Authorization)

2. Round the resulting amount to the nearest dollar.

III. HOW TO MEET A DEDUCTIBLE

A. Date Deductible Is Met

1. The deductible is met on the day that the total of medical expenses applied to the deductible equals the amount of the deductible for the certification period. Refer to MA-2240, Transfer of Assets, to determine when the CAP indicator is entered for CAP applicants/ recipients subject to a deductible and a sanction period.

2. The inpatient hospital admission of an MAABD a/r (who does not have Medicare Part A coverage) is assumed to meet the deductible, regardless of length of stay or the ultimate amount of the charges. (IV.D.-G., below)

3. The inpatient admission to Psychiatric Residential Treatment Facility (PRTF) for an individual under age 21 is assumed to meet the deductible, regardless of length of stay, the ultimate amount of charges or Medicare coverage. PRTF admissions are not covered by Medicare.

(III.)

B. Applying Medical Expenses Incurred During the Certification Period (C.P.)

1. Apply an allowable medical expense (see IV., below) to a deductible in a current c.p. when:

   a. The bill was incurred (paid or unpaid) by the a/r or a responsible person during the c.p. (retroactive or ongoing) for which eligibility is being determined,

      and

   b. The bill is the responsibility of the a/r or a person who is financially responsible for him,

      and

   c. The bill is not subject to payment by insurance or any other party (see V., below), EXCEPT for

      (1) Inpatient hospital or PRTF bills (see IV.D.-G., below) and

      (2) Medical bills paid by a public program of the state, county or city government (see III.C., below).

2. Apply to the deductible only the portion of the bill which has not been paid and is the responsibility of the a/r or a financially responsible person when:

   a. Medicare or other insurance or any individual, not the a/r or person financially responsible for him pays a portion or all of the bill, or

   b. The medical bill is paid under a fee schedule or reduced rate schedule.

C. Medical Expenses Paid by a State, County or City

Medical expenses paid by a state, county or city government program may be applied to the deductible.

1. Apply a medical expense to the deductible if it is paid by a public program totally funded by:

   a. State monies

   b. County monies (including county general assistance)

   c. City government monies.

      See Figure 3 for examples of these public programs.

(III.C.)

2. Do not apply to the deductible a medical expense paid by a public program funded wholly or in part by federal funds.

D. Applying Medical Expenses Incurred Prior to the C.P.

1. Apply a medical expense to a deductible in a current c.p. if it is the unpaid balance of an expense incurred by a budget unit member. Apply it on the first day of the c.p. An old bill is a medical expense:

   a. With a date of service or payment date which is within the 24 months immediately prior to the month of application for a prospective or retroactive c.p., or the 24 months prior to the first month of any subsequent c.p.

      EXAMPLE: An application for Medicaid was made on December 10, 2007, for ongoing coverage and for retroactive coverage for September, October, and November 2007. The unpaid balance of a medical bill that was incurred, or on which any payment was made, on or after December 1, 2005, may be applied to the deductible in either the ongoing or retroactive period.

      AND

   b. Which is a current liability, (that is, has not been written off by the provider), including medical bills paid by a loan, as provided in III.D.3., below,

      AND

   c. Which has not been applied to a previously met deductible.

      (1) If payments are being made on an outstanding medical bill, apply to the deductible the unpaid balance on the first day of the c.p., not the payments.

      (2) When an a/r has been authorized because he was hospitalized (see IV.D., below), Medicaid may not pay because the deductible balance equaled or exceeded the Medicaid payment. In this case, the unpaid hospital bill may not be applied to the deductible in subsequent c.p. It was applied to a previously met deductible.

      AND

   e. Which has not been denied for payment by a third party due to failure to meet the requirements of the insurance plan. (See V.B.3., below)

(III.D.)

2. Carry over to a subsequent c.p. the following expenses if they meet the requirements in III.D.1., above:

   a. The unused portion of an allowable medical expense in excess of the current deductible,

   b. Any expense applied to a deductible which was not met,

   c. Any expense not previously applied to a deductible, and/or

   d. Any expense which was previously reported, but never verified and applied to a deductible.

3. Apply the unpaid balance of a loan used to pay a medical expense incurred prior to the current c.p. on the first day of the c.p. if:

   a. The medical bill meets the requirements in III.D.1., above, except that instead of remaining unpaid, it has been paid by a loan, bank card, or other legally binding financial arrangement which is a liability to the a/r.

   b. To verify the unpaid loan balance:

      (1) Financial Institutions

         (a) Review a copy of the last loan statement from the bank, credit union, or other lending institution, bank statement, or other similar document, prior to the month of the current c.p.

         (b) Subtract the amount of any finance charges shown on the statement to determine the current unpaid loan balance.

      (2) Personal Loans

         For a personal loan from other than a financial institution (friend, relative, etc.) obtained to pay a medical expense, request a verbal or written statement from the lender regarding the original amount, purpose, repayment terms, and the amount of the unpaid balance.

   c. Compare the cost of the medical service(s) paid by the loan to unpaid loan balance on the first day of the c.p.

      (1) If the unpaid balance is less than the cost of the medical service, apply the unpaid balance to the deductible.

      (2) If the unpaid balance is equal to or greater than the cost of medical service(s), apply the full cost of the medical service to the deductible.

(III.D.3.c.)

(3) If the unpaid balance is $0 in this or subsequent c.p.'s, there is nothing to apply to the deductible in that c.p.

d. If the amount of the loan applied to the deductible as determined in III.D.3.c. above, is equal to or greater than the amount of the deductible, any excess remaining after additional payments during c.p. can be carried forward to subsequent c.p.'s as provided in III.D.2., above. If payments on the loan during the c.p. reduce the unpaid balance to $0, there is nothing to carry forward.

e. If the deductible increases because of an increase in income during the c.p., reverify the unpaid loan balance as of the first day of the month of the increased deductible and follow steps in III.D.3.c., above.

f. If payments are being made on the unpaid medical bill, count the unpaid balance on the first day of the c.p., not the payments.

4. If there was health insurance, including Medicare and Medicaid, in effect during the prior period, count the unpaid medical bills only after the status of the insurance claim has been verified. Verify that insurance has either paid or denied the claim. Do not count the unpaid bill toward the deductible if the claim was denied for failure to meet the requirements of the plan. An insurance claim must be filed unless it is verified with the insurance company, Medicare or Medicaid that the time limit for filing has expired. (See V.B., below.)

5. Count the unpaid balance of medical bills incurred prior to a current c.p. in the way that most benefits the a/r and meets the requirements for timely processing of applications.

E. Examples Of Whose Bills To Apply To A Deductible:

1. Recipient in pla is certified for M-AD. His spouse who lives with him is not a Medicaid a/r and has no income. Even though there is no income to deem, she is financially responsible and her medical bills may be applied to his deductible.

2. Recipient in pla is certified for M-AA. His spouse living in the home with him works. Medical expenses of both spouses are counted toward the recipient's Medicaid deductible.

3. Recipient in pla is certified for M-AA. His spouse who receives SSI, is not financially responsible for him. Therefore, only his expenses count toward his deductible.

4. Able-bodied parents apply for M-AD for a disabled dependent child. The parents are financially responsible for the child. Medical expenses of the parents and the disabled child are applied toward the Medicaid deductible of the recipient.

(III.E.)

5. A disabled child eligible for M-AD lives with a parent who receives SSI. The parent is not financially responsible. Therefore, only the child's medical expenses are applied toward the Medicaid deductible.

6. Recipient with a deductible took out a home equity loan for $5,000 at the bank to consolidate all of his bills, including an orthodontist's charge of $2,250 that was incurred prior to the current c.p. He has the provider's bill for the services rendered and a statement showing that the bill was paid. He also has a copy of the promissory note for $5,000 to his bank dated a few days prior to his paying the medical bill and his current statement showing one payment for $100, finance charges of $49, and an unpaid balance of $4,949 ($5,000 - 100 + 49 = $4,949). The total amount of the medical bill can be applied to the a/r's deductible on the first day of the c.p. and carried forward to future c.p.'s as allowed, because the unpaid balance of $4,900, not counting finance charges, exceeds the amount of the medical bill.

7. The a/r always pays his bills, including medical bills, with his MasterCard, wherever it is accepted for payment. He has a copy of the physician's statement showing the date of service and payment rendered by MasterCard for a medical service in the amount of $137 prior to the current c.p. He also presents his MasterCard statement showing an unpaid balance of $392. The finance charges on that statement are $5.88. Subtract the finance charges from the unpaid balance (392 - 5.88 = 386.12). The full amount of the medical expense ($137) can be applied to his Medicaid deductible on the first day of the c.p., because the difference is greater than the amount of his medical charges.

8. The a/r presents his Visa card statement showing an unpaid balance in the amount of $75.96, including a finance charge of $11.25 for that month. He had previously paid a medical bill of $150 for a medical service incurred prior to the current c.p. with his Visa card. Only the amount of the unpaid balance, minus the finance charges on that statement (75.96 - 11.25 = 64.71), can be applied to the Medicaid deductible on the first day of the c.p., because the unpaid balance, minus the finance charges, is less than the medical expense and is the amount he still owes.

F. Notify The Food Stamp Section When A/R Meets A Medicaid Deductible

By copy of DMA-5036, Record of Medical Expenses, and DSS-8194, notify the Food Stamp worker of the change in the Medicaid status of the a/r.

IV. ALLOWABLE CHARGES

A. Medical Expenses Paid By A Third Party (Also see V., Below)

A medical expense paid by a third party other than the a/r or a financially responsible person may not be applied to the Medicaid deductible, EXCEPT inpatient hospital or PRTF bills (see IV.D.-G., below) and a medical expense paid by a public program of state, county, or city government (see III.C., above, and Figure 3).

(IV.)

B. Medical Expenses Applicable To A Deductible

Charges which may be applied to the deductible include, but are not limited to, the following:

1. Medically related services recognized by state tax law;

2. Professional medical services provided by physicians, dentists, therapists, hospitals, clinics, laboratories, or other providers of medical services, including cost of care in approved level in nursing facilities during PLA deductible month;

3. Prescribed medications, over-the-counter non-prescription drugs, and medical supplies, such as aspirin, cold medicines, alcohol, bandages, absorbent pads for the incontinent, and injection syringes and needles, etc.;

4. Medical services incurred during a prior authorized period that are not covered by Medicaid or that are in excess of the allowed coverage (e.g., prescriptions in excess of 6 per month, eyeglasses replaced in less than 1 year, etc.), provided they remain unpaid (see III.D., above);

5. Medically related transportation (actual cost or .25 per mile as allowed by state tax law);

6. Medical equipment, such as eyeglasses, hearing aids, dentures, crutches, braces, etc., that are not paid by Medicaid or other insurance;

7. Health insurance co-payments and deductibles, if not covered by any other third party, and Medicare Part B premiums through the first month of Medicaid authorization; and

8. Private health insurance premiums if the a/r will not be reimbursed.

   a. Health insurance premiums are incurred on the date the payment is due regardless of what months or period of coverage the premium covers.

   b. Do not prorate premiums for more than one month of coverage to a monthly amount.

   c. Insurance premiums cannot be "rolled over" to a subsequent c.p. UNLESS the premiums are unpaid and meet the requirements for bills incurred prior to a current c.p. (See III.D., above.)

   d. If health insurance premiums have been deducted from earned income either as a standard or actual work-related expense, do not apply the cost of the premiums to a Medicaid deductible.

(IV.)

C. Order Of Charges Applied To The Deductible

1. First apply the total unpaid balance of medical expenses incurred prior to the c.p. (old bills) which have not previously been counted and remain unpaid. Deduct these types of charges on the first day of the c.p., ongoing or retroactive. (See III.D., above.)

2. Next, apply charges which are incurred during the c.p. in chronological order. This means day by day, in the order in which they are incurred.

3. Apply charges for medical services which are not covered by Medicaid before applying charges for medical services which are covered by Medicaid.

4. Apply expenses as follows when there are charges for both covered and non-covered expenses incurred on the same date:

   a. Health insurance premiums, including Medicare Part B for applicants, through the month of authorization for Medicaid. (Once the individual is authorized, Medicaid continues to pay the Part B premium until the individual is terminated from Medicaid.)

   b. Medical services not covered by Medicaid, such as medically related transportation, non-prescription drugs, etc.

   c. Medical services covered by Medicaid. (Refer to MA-2905, Medicaid Covered Services.)

   d. When the service is inpatient hospitalization or PRTF, see IV.D.-G., below.

5. A "package fee" (other than for inpatient hospital charges) is a charge for a "package" of medical services. A "package fee" is often charged for prenatal and delivery charges. Also, some dental or orthodontic services are charged as a package. Unless the provider can break out the actual fee for each office visit/service in the "package", the "package fee" can be applied to the Medicaid deductible in one of the following ways:

   a. At the point that the entire "package" of services has been completed or provided, apply the total amount of charges for the "package;" OR

   b. As payments are made towards the bill, apply the amount of the payment on the date the payment is made. Any unpaid balance on the package may be applied only after completion of the "package" of services.

6. Authorize on the date the amount of the medical charges equals the amount of the deductible, provided all other factors of eligibility are met. If a hospital stay is involved, see IV.D.-G., below.

(IV.C.)

7. If an additional medical bill is presented after a case has been authorized, determine whether it will result in an earlier authorization.

   a. Ongoing Case

      (1) If the bill is presented during the c.p., and the deductible is met on an earlier date, authorize the earlier day(s) according to instructions in the EIS USERS MANUAL.

      (2) If the bill is presented after the c.p., apply in the subsequent period(s), if still unpaid. (See III.D., above.)

      (3) Send an adequate notice to notify the individual of the action taken.

   b. Terminated Case

      (1) If the bill is presented within 12 months of the termination date, and the deductible is met on an earlier date, authorize the earlier day(s) according to instructions in the EIS USERS MANUAL.

      (2) If an override of the time limit for filing claims is needed, refer to MA-2395, Corrective Actions and Responsibility for Errors, for procedures.

      (3) Send an adequate notice to notify the individual of the action taken.

8. If medical bills sufficient to meet the deductible are presented on an ongoing case that was certified but not authorized,

   a. Determine the date the deductible was met; and

   b. Authorize according to instructions in the EIS USERS MANUAL.

9. If a change in situation results in a new deductible, apply in the first month of the new deductible period any unpaid bills not previously counted and which meet the requirements in III.D., above.

D. Applying Inpatient Hospital or PRTF Charges to a Deductible - General

1. Admission to a hospital for observation is an outpatient service; do not treat as an inpatient charge.

   NOTE: Apply outpatient hospital or PRTF bills to a deductible following policy for medical bills other than inpatient bills.

2. When a charge for inpatient hospitalization or PRTF was incurred prior to c.p., it is an old bill. Follow policy in III.D. Do not apply the policy in this item (IV.D.-G.).

MEDICAID DEDUCTIBLE

(IV.D.)

3. When an a/r with a deductible or a person who is financially responsible for him is hospitalized during the c.p. for which eligibility is being determined, determine how the bill is applied to the deductible based on the following factors:

- To whose deductible is the bill being applied?
- Who is the hospitalized person? Is he the person with the deductible to which the bill is being applied or is he financially responsible for the person with the deductible?
- If he is a financially responsible person, is he also an a/r?

a. These factors determine whether to use the procedures in IV.E., F., or G. to apply the bill to the deductible.

b. Follow instructions in 4.-6. below to determine which procedures to use.

4. Follow procedures in IV.E. for applying a hospital bill to a deductible when:

a. The deductible is for a Medicaid individual, Medicaid child, or a spouse in a Medicaid couple, and

b. The hospitalized person is the same Medicaid individual, the same Medicaid child, or a member of the same Medicaid couple.

5. Follow procedures in IV.F. for applying a hospital bill to a deductible when:

a. The deductible is for a Medicaid individual with an ineligible spouse or for a Medicaid child, and

b. The hospitalized person is the financially responsible ineligible spouse or a parent of the Medicaid child, and

c. The hospitalized person is also an a/r with a deductible.

6. Follow procedures in IV.G. for applying a hospital bill to a deductible when:

a. The deductible is for a Medicaid individual with an ineligible spouse or for a Medicaid child, and

b. The hospitalized person is the financially responsible ineligible spouse or the parent of the Medicaid child, and

c. The hospitalized person is not an a/r.

(IV.)

E. Applying Inpatient Hospital Charges of an A/R to His Deductible (See IV.D.4., above to determine if IV.E. applies.)

1. Inpatient hospital charges of an a/r meet his deductible, regardless of length of stay, amount of charges, or other third party liability, unless the a/r is admitted to the hospital and has Medicare Part A coverage.

   a. Inpatient PRTF charges of an a/r under the age of 21 meet his deductible regardless of length of stay, ultimate amount of charges, Medicare coverage or other third party liability. PRTF admissions are not covered by Medicare.

   b. If the a/r does have Medicare Part A coverage and is admitted to a hospital, apply only the amount of the Part A deductible to the Medicaid deductible.

      (1) The Part A deductible is due on the date of admission under DRG only when a new Medicare benefit period has begun. (See V.C.1., below.) Determine from contact with the a/r or the hospital whether there has been a previous hospitalization in the last 60 days and whether the Part A deductible is applicable to the current hospitalization. Apply the total Medicare Part A deductible toward the Medicaid deductible on the admission date only if the a/r is responsible for paying it.

      (2) Apply the Part A deductible amount to the Medicaid deductible on the date of admission, prior to applying other Medicaid covered charges incurred on the same date.

      (3) If the Part A deductible meets the Medicaid deductible, authorize the a/r effective the date of admission. The deductible balance is the amount of the Medicare Part A deductible, or the amount of the Medicaid deductible remaining on the date of admission, whichever is less.

      (4) If the Part A deductible does not meet the Medicaid deductible, or if the a/r does not owe the Part A deductible because he had a prior hospitalization, continue applying other charges to the deductible, following procedures in IV.C.4., above, until the deductible is met.

      (5) If the Medicaid deductible is met during the hospitalization but after the date of admission, authorize effective the date the deductible is met.

         (a) If the Medicare Part A deductible is applied to the Medicaid deductible, the deductible balance is always the amount of the Medicare Part A deductible. (See VII.A.2., below.) This is the amount owed by the a/r to the hospital.

(IV.E.1.b.5)

(b) If the Part A deductible was not applied, the deductible balance is always 0. The a/r does not owe for any of the hospital charges.

NOTE: Under DRG, the entire hospital bill will be paid by Medicare and Medicaid, less the deductible balance, if the a/r is authorized on any day during the hospitalization.

(6) If the deductible is met during the hospitalization, complete a DMA-5020.

(a) Medicaid authorization is the date the deductible is met (the same date entered in EIS), and

(b) The amount of "Patient payment due the hospital" entered in item 5.a. is the amount calculated in IV.E.1.b.(3)-(5), above.

EXAMPLE 1: Mr. Dunn has a deductible and has Medicare Part A. He enters the hospital on 7/5 and remains until 7/12. The amount of his deductible remaining on the date of admission is $3,450. The Part A deductible of $1,132 is applied on 7/5 leaving $2,318 remaining. Mr. Dunn's out of pocket expenses during his hospital stay total $1,050. After his hospital stay he still has $1,268 of his deductible left to meet.

EXAMPLE 2: Ms. Horowitz has a deductible and has Medicare Part A. She enters the hospital on 8/2 and remains until 8/27. The amount of her deductible remaining on the date of admission is $459. The Part A deductible of $1,132 is applied on 8/2 and she meets her deductible. Ms. Horowitz is authorized effective 8/2 with a deductible balance of $459.

EXAMPLE 3: Ms. Wright has a deductible and has Medicare Part A. She enters the hospital on 6/25 and remains until 6/30. The amount of her deductible remaining on the date of admission is $1,155. The Part A deductible of $1,132 is applied on 6/25 leaving $23 remaining. Ms. Wright's share, after Part B, of the doctor’s charges meets her deductible on 6/26. Ms. Wright is authorized effective 6/26 with a deductible balance of $1,132.

2. If the a/r does not have Medicare Part A:

a. Authorize the a/r (or Medicaid couple) effective the date of admission to the hospital or PRTF.

b. To determine the deductible balance:

(1) Determine the amount of the deductible remaining on the date of admission.

04/01/02

(IV.E.2.b.)

(2) Subtract the charges for any medical services not covered by Medicaid incurred on the day the deductible is met; e.g. health insurance premiums, non-prescription drugs, etc.

Refer to MA-5100, Services Covered by Medicaid.

EXAMPLE: Mr. Jones is certified February through July. deductible is $1836. He is hospitalized on April 12. He does not have Medicare Part A. Prior to April 12 he incurred $747 in medical bills to apply to his deductible. He is authorized effective April 12 and his deductible balance is $1089.

c. Enter this amount in EIS as the deductible balance.

d. Complete a DMA-5020.

(1) Medicaid authorization is the date of admission (the same date as entered in EIS), and

(2) The amount of "Patient payment due the hospital" entered in item 5.a. is the amount calculated in IV.E.2.b., above.

3. Insurance**{** XE "Insurance" **}**

a. When the a/r has Medicare A, his hospital claim will be billed to Medicare first then crossed-over to Medicaid which will deduct the Medicaid deductible balance entered in EIS from payment.

b. If the a/r has private insurance, be sure that it is on file in EIS so that it will pay before Medicaid. His hospital claim must be billed to insurance before Medicaid pays. Medicaid will pay the remaining amount after deducting the deductible balance entered in EIS.

4. If the recipient met his deductible with hospitalization but a change in situation causes an increased deductible, he must meet the additional deductible to be authorized for any remaining portion of the c.p.

F. Applying Inpatient Charges of an A/R Parent or Ineligible Spouse to the Deductible of His Child or Spouse (See IV.D.5., above to determine if IV.F. applies.)

When an a/r is also a financially responsible parent or spouse for his child/spouse with a separate deductible, and the a/r has an inpatient hospitalization during the current c.p., do not assume the a/r's hospital bill will meet the deductible for his child/spouse. How the bill is applied to the child/spouse depends upon whether the hospitalized a/r has Medicare Part A and whether the hospitalization meets his own deductible.

1. Follow instructions in IV.E., above to apply inpatient hospital or PRTF charges to the a/r's own deductible (or MA-3315, Medicaid Deductible IV.E. if he is an MAF a/r).

(IV.F.2.)

2. If the hospitalized a/r does not have Medicare Part A, the hospitalization meets his Medicaid deductible on the date of admission. Treat his deductible balance on the date of admission as a medical bill to apply to the deductible for his child/spouse.

EXAMPLE 1: Father receiving MAD has a deductible. His 10 yr. old child is an MAD child with a deductible. The father is the financially responsible parent of the child. Father has monthly unearned income of $880. Child has monthly unearned income of $600. (Father does not have Medicare Part A coverage.)

Father's budget:		Child's budget:	
$880	Income	$600	Child's Income
- 20		+ $366	Deemed from Father
$860		$966	
- 242		- 20	
$618		$946	
x 6		- 242	
$3,708	Deductible	$704	
		x 6	
		4,224	

The father is hospitalized. Assuming he had no other medical expenses, he would be authorized for MAD on the date of hospital admission. His deductible balance is $3,708. Apply this amount to the child's deductible.

$4,224	Child's deductible
- $3,708	Father's deductible balance
516	Child's remaining deductible

3. If the hospitalized a/r has Medicare Part A (and the admission is not to a PRTF), only the Part A deductible may be applied to his Medicaid deductible. Apply the a/r's hospitalization charges to the deductible of his child/spouse as follows:

a. If the Part A deductible meets the hospitalized a/r's deductible on the date of admission, treat his deductible balance as a medical charge to apply to the deductible for his child/spouse.

b. If the Part A deductible does not meet the hospitalized a/r's Medicaid deductible on the date of admission, apply his Part A deductible amount to the deductible for his child/spouse on the date of admission. Continue applying charges incurred by the hospitalized a/r to his deductible and to the deductible of his child/spouse.

c. If the hospitalized a/r's deductible is met during the hospitalization on any day after the date of admission, and his Part A deductible was applied to his Medicaid deductible, his deductible balance is always the amount of the Medicare Part A deductible. This amount has already been applied to the child/spouse's deductible on the date incurred, therefore do not apply the deductible balance to the child/spouse's deductible.

(IV.F.3.)

EXAMPLE 2: Same situation as Example 1, except father has Medicare Part A. He enters the hospital on 1/4 and it is a new Medicare benefit period. Prior to 1/4 he has incurred $500 in medical charges which have been applied to his deductible and to his child's deductible.

Father is hospitalized 1/4 - 1/10. The Part A deductible of $1,132 is applied to his Medicaid deductible on 1/4, the date of admission, leaving $2,076 still to be met. The $1,132 is also applied to the child's deductible. Other charges are incurred on 1/5 and 1/6 totaling $2,024. 1/7 the father incurs a $500 charge which meets his deductible.

Father's deductible		Child's deductible	
$3,708		$4,224	
- 500		- 500	
3,208		3,724	
-1,132	Part A deductible	-1,132	Part A deductible
2,076	Remaining	2,592	Remaining
-2,024	Additional charges	-2,024	Additional charges
52	Remaining	568	Remaining
- 500	1/7 charges	- 52	Father’s deductible balance
		516	Deductible remaining

Father is authorized on 1/7 with a deductible balance of $1,132. Child's remaining deductible on 1/7 is $516.

G. Applying Inpatient Charges of a Financially Responsible Person Who Is Not an A/R (See IV.D.6. above, to determine if this applies.)

1. Apply inpatient bills of a financially responsible person who is not an a/r on a daily basis as they are incurred to the a/r's deductible.

2. If the inpatient bills were incurred prior to the c.p., follow instructions in III.D., above.

V. THIRD PARTY RESPONSIBILITY

When applying hospital bills of the a/r to the deductible, refer to IV.D., above.

A. Bills For Which There Is Third Party Responsibility

1. Do not count a medical expense that anyone, other than the a/r or a person who is financially responsible for the a/r, has paid or agreed to pay, UNLESS the third party is a public program of state, county, or local government. See III.C., above, and Figure 3.

2. Do not count unpaid medical bills from a prior c.p. of an a/r or any financially responsible person who also is a Medicaid a/r and whose case you know to be either pending or on appeal, if the bills may eventually be paid by Medicaid. If the pending or appealed case is ultimately denied, the bills may be applied in a subsequent c.p.(s).

(V.A.)

3. If a bill was applied to a deductible and later that bill is covered in a period that is authorized because of an appeal or subsequent approval of Social Security or SSI disability, etc., no action is necessary.

4. Do not count toward a deductible any medical bill incurred prior to a current c.p. which any other party has been court-ordered to pay.

   NOTE: A court order to provide medical insurance is not an order to pay a medical bill. If an absent parent has failed to provide insurance as ordered by the court, a referral to IV-D may appropriate.

5. Do not count unpaid medical bills that would have been subject to payment by a third party had the requirements of the insurance plan been met. (See V.B., below.)

B. Third Party Insurance Coverage (Other Than Medicare)

The following are instructions for applying medical charges to a deductible when there is insurance coverage, other than Medicare. (See C., below, for Medicare information.)

1. Determine from the insurance explanation of benefits (EOB) or contact with the insurance company or medical provider whether insurance has paid, and if denied the reason for the denial. If the EOB does not explain why the claim was denied, contact the insurance company.

2. When insurance has paid on a bill, verify the amount of the insurance payment.

   a. The amount of medical expenses above the amount of the insurance payment is the amount for which the a/r is still liable and which is counted towards the Medicaid deductible.

   b. If the insurance payment was made directly to the person who never paid the medical provider, count only the amount of the bill less the amount insurance paid to the person.

   c. For hospital bills of the a/r, refer to IV.D., above.

   d. Hospital Charges of Financially Responsible Non-A/R's

      Determine the non-a/r's responsibility per day for the hospitalization:

      (1) Insurance payment amount divided by the number of hospital days (excluding the day of discharge) equals the average daily insurance payment.

      (2) Total hospital charges divided by the number of hospital days excluding the day of discharge) equals the average daily charges.

(V.B.2.d.)

(3) Subtract the average daily insurance payment from the average daily charges to determine how much to apply to the Medicaid deductible.

(4) Apply this amount on a daily basis.

e. Physicians' Charges

Count the difference between the insurance payment and total charges as stated on the insurance EOB. If the physician's bill is for several days' services and billed as a lump sum, determine the a/r's responsibility to pay as in V.B.2.a.

3. When insurance, including Medicaid, has denied the claim because of noncompliance with the requirements of the plan by the a/r or a person who is financially responsible for the a/r, do not apply the charge to the deductible.

a. Common examples of noncompliance denials are:

Non-participating provider
Failure to obtain pre-approval
Exceeds time limit for filing
Service not provided in proper location
Service not payable separately but is lumped with payment for other services
Failure to give provider Medicaid card

b. Noncompliance DOES NOT include denials that are outside the control of the a/r, such as non-covered services or denials due to failure of providers to meet their responsibility.

4. When insurance has not processed the claim:

a. Applications

(1) For bills incurred during a current (retroactive or ongoing) c.p., verify with the medical provider or insurance company whether insurance is likely to process the claim within the 45/90 day application processing period.

(a) If likely to process the claim within the application processing period, hold the application pending for insurance payment.

1) When insurance pays, verify the amount of the outstanding balance owed by the a/r after deducting the insurance payment. Proceed as in V.B.2.

2) If the insurance denies due to noncompliance, do not apply the charge to the deductible. (See V.B.3.)

3) If insurance has not processed by the 45/90th day, apply the full charge to the deductible.

(b) If not likely to complete processing the claim within the 45/90 day period, apply the total expense to the deductible.

(c) Do not hold an application pending beyond 45/90 days if insurance will not complete processing the claim within the application processing period.

(2) For bills incurred prior to a current c.p., verify whether insurance has denied payment or has not been filed.

(a) If denied due to failure to meet the requirements of the plan, do not apply the charge to the deductible. (See V.B.3.)

(b) If denied for some other reason, count the unpaid balance owed by the a/r.

(c) If not filed, a/r must file a claim, unless it is verified with the insurance company that the time limit for filing claims has expired.

(d) Count unpaid balance owed by a/r only after insurance response has been verified.

(e) If the insurance claim is still pending, do not apply the charges to the deductible until the claim has completed processing.

b. Ongoing Cases

(1) For bills incurred during a current c.p., verify with the medical provider or insurance company whether insurance has paid.

(a) If not, apply the total expense to the deductible.

(b) If the insurance denied due to failure to meet the requirements of the plan, do not apply the expense to the deductible.

(c) If the insurance denied for some reason other than noncompliance, apply the total expense owed by the a/r to the deductible.

(2) For bills incurred prior to a current c.p. and when there was insurance coverage, verify whether insurance paid or denied payment, and if denied the reason for the denial, and the amount of the unpaid balance owed by the a/r.

(a) If the insurance has not paid due to failure to meet the requirements of the plan, do not apply the expense to the deductible.

(b) If the insurance has not paid for some reason other than noncompliance, apply the total expense owed by the a/r to the deductible.

(3) Apply the expense only after the insurance response has been verified.

5. Inform the a/r that all insurance reimbursement rights are assigned to Medicaid if insurance later pays medical expenses that have been paid by Medicaid. Submit a DMA-2041. See MA-2400, Third Party Recovery, and EIS USERS MANUAL.

c. Medicare Coverage

The following is a summary of current Medicare benefits and instructions for applying medical charges to a deductible when there is Medicare coverage. (See B., above, for other third party insurance information.)

1. Inpatient Hospitalization - For inpatient hospital bills of a/r's, see IV.D.-G., above. Only the portion of hospital charges the a/r or a financially responsible person is responsible for paying is applicable to a Medicaid deductible.

a. Deductible

The individual is responsible for the Part A deductible of $1,132 per benefit period.

b. Coinsurance

(1) $283.00 per day for the 61st - 90th days

(2) $566.00 per day for 60 lifetime reserve days

c. Benefit Period

A benefit period begins the first time a person enters a hospital or SNF under Medicare. Up to 90 days of hospital care and up to 100 days of skilled care in a NF are available for each benefit period. A new benefit period begins once the person has been out of the hospital or NF for 60 consecutive days. There is no limit on benefit periods.

d. Diagnosis Related Groupings (DRG's)

(1) Medicare reimburses general hospitals on the basis of Diagnosis Related Groupings.

(2) If the person is admitted under a Medicare DRG and a new Medicare benefit period has begun, the entire Medicare Part A deductible is due on the date of admission. Apply the total Medicare Part A deductible toward the Medicaid deductible on the admission date

(V.C.1.d.)

(3) In some instances, Medicare may exempt the specialty unit (psychiatric or rehabilitation) of a general hospital from the hospital DRG and reimburse the hospital based on the costs of services provided.

(a) If the patient is admitted to a psychiatric or rehabilitation unit of a general hospital, verify with the hospital whether Medicare will pay based on DRG or on costs of services provided.

(b) If paid based on DRG, follow V.C.1.c.(1) & (2), above.

(c) If paid based on cost of service provided, apply the amount of hospital charges as they are incurred until they total Medicare deductible.

2. Nursing Facility (NF)

Medicare pays the first 20 days of skilled care in a Medicare certified medical institution. Eligible individuals incur a co-insurance amount of $141.50 per day, for the 21st through the 100th day of skilled care. There is no Medicare coverage for skilled care after the 100th day. The facility usually determines whether care is Medicare-covered and for how long.

3. Medical Insurance - Medicare Part B

a. The a/r is responsible for the Medicare Part B premium of $96.40 (protected amount if premium deducted as of 2009), $110.50 (protected amount if premium amount deducted beginning 2010) or $115.40 (2011 premium amount and actual amount paid by state regardless of a/r's premium amount) per month until he goes on Medicare Buy-In.

b. The a/r is responsible for the Medicare Part B deductible of $135 for the calendar year.

c. Medicare Part B pays for outpatient physician services and other outpatient services. It may also pay for some other medical services not covered by Part A when the patient is hospitalized, such as laboratory charges, x-rays, etc.

4. Applying A Medicare Patient's Non-Inpatient Hospital Charges To A Current Medicaid Deductible

a. Apply to the Medicaid deductible only those charges for which the a/r or person financially responsible for the a/r is responsible.

b. The Medicare patient is responsible for the following:

(1) Charges for the first 3 pints of blood.

07/01/98

(V.C.4.b)

(2) For bills for the current c.p.:

(a) If the Medicare EOB is available, compute the a/r's liability as follows:

1) If the provider accepts assignment, count the difference between the Medicare approved amount and the Medicare payment amount as the a/r's liability.

2) If the provider does not accept assignment, count the difference between the actual charges and the Medicare payment as the a/r's liability.

(b) If the Medicare EOB is not available, count 20% of the actual charges, unless the a/r has a "Q" classification showing eligibility for Medicare-Aid (M-QB). (Assume the $100 Medicare deductible has been met.)

(3) For bills incurred prior to a current c.p., the IMC must verify whether Medicare has been filed and has paid or denied payment and the amount of the unpaid balance owed by the a/r. The a/r must file a claim unless it is verified that the time limit for filing claims has expired. Do not project 20% for these bills.

(4) If the a/r provides the EOB within 90 days of the previous authorization date and actual charges exceed the estimated amount, determine if the deductible was met earlier. If so, authorize according to instructions in the EIS USERS MANUAL. The a/r must provide the EOB within 90 days of the previous authorization date.

VI. DOCUMENTATION AND VERIFICATION

A. Bills Incurred During C.P.

Verify expense incurred during the current c.p. by examining receipts, bills, and statements.

B. Bills Incurred Prior to C.P.

Verify the unpaid balance of bills incurred prior to a current c.p. for:

1. Applications as of the first day of the c.p.

2. Redeterminations:

a. Verify the unpaid balance of medical expenses no more than 30 days prior to the date the review is completed.

b. Apply the unpaid balance on the first day of the c.p.

(VI.)

C. Verifying Medical Expenses From Provider

Complete the DMA-5037, Medical Provider Verification Form (see MA-2360-Figure 1), for each identified medical provider. The a/r may assume responsibility for obtaining provider verification, but IMC must assist if the a/r requests assistance. The a/r may also meet this requirement by presenting a current bill that includes:

1. Date of service
2. Type of service
3. Amount of total charges
4. Status of bill (whether paid or unpaid), and
5. Date of last payment on account
6. Amount of last payment, and
7. Amount of unpaid balance

D. Third Party Liability Coverage

When there is third party insurance coverage at the time a medical charge is incurred, document the status of the insurance claim by reviewing the Explanation of Benefits or contacting the insurance company or medical provider.

If the claim has been denied, document the reason for the denial. This is necessary to determine what remaining charges, if any, may be applied to the a/r's deductible. (Refer to V.B.3., above.)

If the insurance claim is denied because the a/r or a financially responsible person did not comply with the requirements of the plan, Medicaid will not pay the remaining charges nor can the charges be applied to the a/r's deductible.

E. Documentation Of Medical Expenses Applied To The Deductible

Document charges applied to the current Medicaid deductible on DMA-5036, Record of Medical Expenses Applied to the Deductible (see MA-2360-Figure 2). Include date of service, patient name, provider name, and amount for each charge. If the a/r is not responsible for the entire charge, include the amount for which he is responsible. If medical bills are for dates of service prior to the current c.p., verify the a/r's current liability.

1. Document the following for all medical bills; except inpatient hospital bills of an a/r during the current c.p.:

   a. Date of service
   b. Type of service
   c. Amount of total charges

04/01/02

(VI.E.)

2. For inpatient hospital or PRTF admissions of the a/r in the current c.p., verify date of admission and confirm that the stay was considered inpatient.

3. In addition to items in VI.D.1. and 2., above for medical bills, including hospital bills, incurred prior to the current c.p. document the following:

   a. Status of bill (whether paid or unpaid). If paid by a loan, see III.D.3., above, for procedures regarding loans to pay medical expenses.
   b. Amount applied to deductible
   c. Amount of unpaid balance
   d. Date of verification of the unpaid balance

VII. AUTHORIZATION AND REPORTING OF DEDUCTIBLE BALANCE

A. Determining the Deductible Balance

1. The deductible balance is the total amount of the deductible remaining to be met on the date the case is authorized. This is the amount entered in EIS.

2. Inpatient Hospitalization - The deductible balance is reported to the hospital as the liability on the DMA-5020, and must be the same as the deductible balance entered in EIS. Determine the deductible balance as follows:

   a. No Medicare Part A

      If the hospitalization meets the Medicaid deductible on the date of admission because there is no Medicare Part A, the deductible balance is the amount of the deductible remaining to be met on the date of admission after subtracting non-covered medical expenses. (See IV.D.-E., above.)

   b. Medicare Part A Deductible Meets Medicaid Deductible on Date of Admission

      If the Medicare Part A deductible meets the Medicaid deductible on the date of admission, the deductible balance is the amount of the Medicare Part A deductible, or the amount of the Medicaid deductible remaining on the date of admission, whichever is less. (See IV.D.-E., above.)

(VII.A.2.)

c. Deductible Met After Date of Admission But During Hospitalization

If the Medicaid deductible is met during the hospital stay but after the date of admission, the deductible balance is always the amount of the Medicare Part A deductible which was applied to the Medicaid deductible. This is the amount owed by the a/r to the hospital.

If the a/r's Part A deductible was met in a previous hospitalization and was not applied to the current hospitalization, the deductible balance is $0.

d. If the deductible is not met during the hospital stay, continue to apply charges as incurred.

B. Case Authorization (See EIS USERS MANUAL)

1. Authorize the case when documented medical expenses equal the amount of the deductible. Enter in EIS the deductible balance amount on the date of authorization.

   a. If the deductible is met by an a/r's inpatient hospitalization or PRTF admission, enter the same deductible balance into the deductible balance field in EIS that is reported to the hospital or PRTF on the DMA-5020. (Refer to IV.D. and E., above.)

   b. If inpatient hospitalization of the a/r is not involved, report the total deductible balance in EIS as the amount of deductible met on the date of authorization.

2. Do not report a deductible balance in EIS when medical bills incurred prior to the current c.p. were used to meet the deductible on the first day of the c.p.

C. Reporting the Deductible Balance

1. Report to the hospital or PRTF on DMA-5020 the amount of "Patient due the hospital" in item 5.a. (Refer to MA-5000)

2. See IV.E.2.b. and VII.A.2. above for how this amount is calculated.

3. This amount must be the same amount that is entered on the computer input document as deductible balance.

D. Covered And Non-Covered Expenses

When both covered and non-covered medical expenses are incurred on the same day, all non-covered medical expenses are to be counted toward the deductible before covered expenses are counted. (See IV.C.4., above.)

MA-2360: FIGURE 4