# MA-3315 MEDICAID DEDUCTIBLE
**REISSUED 1/01/09 – CHANGE NO. 02-09**

## I. POLICY PRINCIPLE{ XE "MEDICAID DEDUCTIBLE" }

An a/r whose net countable income exceeds the income limit must meet a deductible before he may be authorized for Medicaid. See MA-3305, M-AF, M-IC, H-SF Budgeting, for determining deductible amount.

The policy in this section may not be used to find a client eligible under Categorically Needy (C or N Classification) regulations. Deductibles do not apply to Categorically Needy coverage groups.

## II. HOW TO MEET A DEDUCTIBLE

### A. When 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, in the Aged, Blind, And Disabled Medicaid Manual 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 a Medicaid a/r (who does not have Medicare Part A coverage) is assumed to meet the deductible on the date of admission, regardless of length of stay or the ultimate amount of charges. (See III. B.)

3. The inpatient admission of an individual under age 21 to a Psychiatric Residential Treatment Facility (PRTF) 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.

### B. Whose Bills to Apply to the Deductible

1. Apply medical bills of any budget unit member.

2. Examples:

   a. An individual, age 20, is certified for M-AF. He lives with his able-bodied parents. The b.u. is three persons. Medical expenses of the 20 year old and his parents are counted toward the deductible.

   b. A child, age 15, lives with his mother. Both apply for M-AF. The budget unit is 2 and their countable income exceeds 200% of poverty. Medical expenses of both the child and the mother apply to the deductible.

c. A child, age 19, lives with his mother and his two siblings who are under age 6. The mother's countable income exceeds the MAF-CN income limit, but is under 133% of poverty. The two younger children are eligible for M-IC. The mother and the 19 year old child apply for M-AF. The budget unit is the mother and the 19 year old child. Only their medical bills apply to the deductible. The two younger children are in the needs unit, because the mother is financially responsible for them. However, only bills of those in the budget unit may apply to the deductible.

**C. Allowable Expenses**

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. Services covered by NC Medicaid;

3. 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;

4. 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.;

5. 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.A.1.);

6. Medically related transportation (actual cost or .25 per mile);

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

8. 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

9. 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.A.1)

**(II.C.9.)**

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.

## III. APPLYING BILLS TO DEDUCTIBLE

### A. Order

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

a. An old bill is a medical expense:

(1) 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 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

(2) 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 V.

AND

(3) Which has not been applied to a previously met deductible.

(a) If payments are being made on an outstanding medical bill, count the unpaid balance on the first day of the c.p., not the payments.

(b) When an a/r has been authorized because he was hospitalized (see B.), 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 a subsequent c.p. It was applied to a previously met deductible.

AND

(4) Which has not been denied for payment by a third party due to failure to meet the plan requirements. (See IV.B.3.)

**(III.A.1)**

b. Carry over to a subsequent c.p. the following expenses if they meet the requirements in A.1.a.:

(1) The unused portion of an allowable medical expense in excess of the current deductible,

(2) Any expense applied to a deductible which was not met,

(3) Any expense not previously applied to a deductible, and/or

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

c. 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 IV.B)

d. If an old bill could be applied in more than one c.p. explain the options to the client and allow him to choose how to apply the bill. Document the explanation in the case record.

e. 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.

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

a. Charges incurred (paid or unpaid) by a current b.u. member during the c.p. (retroactive or ongoing) for which eligibility is being determined,

And

b. The charge is the responsibility of a current budget unit (b.u.) member,

And

c. The charge is not subject to payment by insurance or any other third party (see IV.), EXCEPT for :

(1) Hospital bills (see B.) and

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

d. 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 current b.u. member when :

(1) Medicare or other insurance or any individual, not the a/r or a current b.u. member, pays a portion or all of the medical bill, or

(2) The medical bill is paid under a fee schedule or reduced rate schedule.

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

3. 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-3540, Medicaid Covered Services.)

d. When the service is inpatient hospitalization, see B.

4. 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

**(III.A.4.)**

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.

**B. Applying Inpatient Hospital Bills to a Deductible**

1. General

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

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

b. When a charge for inpatient hospitalization or PRTF admission was incurred prior to the c.p., it is an old bill. Follow policy in A.1. Do not apply the policy in this item, B.

c. When an a/r with a deductible or a person who is financially responsible for him has an inpatient admission during the c.p. for which eligibility is being determined, how the hospital bill is applied to the deductible depends on the following factors:

(1) To whose deductible is the bill being applied?

(2) Who is the hospitalized person? Or the person in PRTF? 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?

(3) If he is a financially responsible person, is he also an a/r?

(a) These factors will determine whether to use the procedures in B.2, 3, or 4. to apply the hospital bill to the deductible.

(b) Follow procedures in d-f. below to determine which policy to use.

d. Follow procedures in III.B.2. for applying a hospital bill to a deductible when the hospitalized person is a member of the a.u. for whom eligibility is being determined.

e. Follow procedures in B.3. for applying a hospital bill to a deductible when:

(1) The deductible is for an a.u. that does not include the hospitalized person, and

(2) The hospitalized person is in the b.u. of that a.u., and

(3) The hospitalized person is an a/r in another a.u. with a deductible.

(III.B.1.)

f. Follow procedures in B.4. for applying a hospital bill to a deductible when:

(1) The deductible is for an a.u. that does not include the hospitalized person, and

(2) The hospitalized person is in the b.u. of the a.u. that has the deductible, and

(3) The hospitalized person is not in another a.u.

2. Applying Inpatient Hospital or PRTF Charges of a Member of the A.U. to the Deductible for His A.U. (Refer to B.1.e. to determine if B.2. applies.)

a. Inpatient hospital charges of an a/r meet the a.u.'s deductible, regardless of length of stay, amount of charges, or other third party liability, unless the a/r has Medicare Part A coverage.

b. Inpatient PRTF charges of an a/r meet the a.u.'s deductible, regardless of length of stay, ultimate amount of charges, Medicare coverage, or other third party liability. Medicare Part A does not cover PRTF charges.

c. If the a/r has Medicare Part A coverage, and is admitted to a hospital, apply only the amount of the Part A deductible to the a.u.'s 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 IV.C.1.) 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 a.u.'s Medicaid deductible, authorize the a.u. 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.

EXAMPLE: The MAF a.u. that includes Ms. Martinez has a Medicaid deductible and Ms. Martinez has Medicare Part A. She enters the hospital on 8/2 and remains until 8/27. The amount of the a.u.'s Medicaid deductible remaining on the date of admission is $459. The Part A deductible of $1,132.00 is applied on 8/2 and meets the Medicaid deductible. The a.u. is authorized effective 8/2 and Ms. Martinez' Medicaid deductible balance is $459.

(III.B.2.c.)

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 order in A.2-4. until the deductible is met.

(5) If the Medicaid deductible is met during the hospitalization but after the date of admission, authorize the a.u. 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. This is the amount owed by the a/r to the hospital.

EXAMPLE: The MAF a.u. that includes Mr. Chang has a Medicaid deductible, and Mr. Chang has Medicare Part A. He enters the hospital on 6/25 and remains until 6/30. The amount of the a.u.'s Medicaid 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. Mr. Chang's share, after Part B, of the doctor's charges meets the deductible on 6/26 and the a.u. is authorized on 6/26 with a Medicaid deductible balance of $1,132.

(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 part A deductible and other expenses incurred while in the hospital do not meet the a/r's deductible, the amount remaining after deducting these amounts is the amount of his deductible left to meet.

EXAMPLE: The MAF a.u. that includes Mr. Riley has a Medicaid deductible, and he has Medicare Part A. He enters the hospital on 7/5 and remains until 7/12. The amount of the a.u.'s Medicaid 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. Riley's out of pocket expenses during his hospital stay total $1,050. After his hospital stay, the a.u. still has $1,268 of the Medicaid deductible left to meet.

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

(1) Authorize the a.u. effective the date of admission to the hospital or PRTF.

(2) To determine the deductible balance:
Determine the amount of the deductible remaining on the date of admission.

**05/01/02**

**(III.B.2.d.(2))**

(b) 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. The remaining amount is the deductible balance to be entered in EIS and reported on the DMA-5020.

Refer to MA-5100, Medicaid Covered Services.

EXAMPLE: The MAF a.u. that includes Mr. Jones is certified February through July. The deductible is $1,836. He is hospitalized on April 12. He does not have Medicare Part A. Prior to April 12 the b.u. had incurred $747 in medical bills to apply to the deductible. Authorize effective April 12 and his deductible balance is $1,089.

e. Insurance

If the a/r has private insurance, be sure that it is on file in EIS so that it will pay before Medicaid. The hospital must bill the insurance company, including the Medicare carrier, before Medicaid pays. Medicaid is always last payor when the a/r has other health insurance coverage.

f. If the recipient met his deductible with hospitalization but has a change in situation that causes an increased deductible, he must meet the additional deductible to be authorized for any remaining portion of the certification period.

3. Applying Inpatient Charges of an A/R to the Deductible of Another A.U. (Refer to III.B.1.e. to determine if III.B.3. applies.)

When an a/r who is also a financially responsible parent or spouse for his child/spouse in another a.u. with a 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's a.u. How the bill is applied to the other a.u. depends upon whether the hospitalized a/r has Medicare Part A (Not applicable to PRTF admission, which is not covered by Medicare.) and whether the hospitalization meets his own deductible.

a. Follow instructions in B.2 to apply inpatient hospital or PRTF charges to the a/r's own deductible (or MA-2360, Medicaid Deductible, if he is an MAABD a/r).

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

(III.B.3.b.)

EXAMPLE 1: Father receiving MAD has a deductible. His 10 yr. old child is an MAF child with a deductible. The father is the financially responsible parent of the child and is in his b.u. Father has monthly unearned income of $880. Child has monthly unearned income of $400. (Father does not have Medicare Part A coverage.)

| Father's budget: | | Child's budget: | |
|---|---|---|---|
| $880 | Income | $400 | Child's income |
| -20 | | + $880 | Father's income |
| $860 | | 1,280 | |
| - 242 | | - 317 | |
| $618 | | 963 | |
| x 6 | | x 6 | |
| $3,708 | Deductible | 5,778 | |

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.

| | |
|---|---|
| $5,778 | Child's deductible |
| -$3,708 | Father's deductible balance |
| 2,070 | Child's remaining deductible |

c. If the hospitalized a/r has Medicare Part A, only the Part A deductible may be applied to his Medicaid deductible. Apply the a/r's hospitalization charges to the deductible of the a.u. of his child/spouse as follows:

(III.B.3.c.)

(1) If the Part A deductible meets his Medicaid deductible during the hospitalization, treat his deductible balance on the day of authorization as a medical charge to apply to the Medicaid deductible for the a.u. of his child/spouse.

(2) If the Part A deductible does not meet his Medicaid deductible on the day of admission, apply the Part A deductible amount to the deductible for the a.u. of 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.

(3) Once the hospitalized a/r's deductible is met, treat his deductible balance on the day of authorization as a medical bill to apply to the deductible of the a.u. of his child/spouse.

EXAMPLE 2: Same situation, except father has Medicare Part A. The Part A deductible of $1,132 is applied to his Medicaid deductible on January 4, the date of admission, leaving $2,640 still to be met. The $1,132 is also applied to the child's deductible. Other charges are incurred on January 5 and January 6 totalling $2,612. The father incurs $400 on January 7 and he meets his deductible on January 7, while still in the hospital. The deductible balance reported in EIS and to the hospital is the Medicare Part A deductible ($1,132). Refer to B.2.c.(3). The amount of his deductible remaining on January 7 ($28) is applied to his child's deductible.

| Father's deductible | | Child's deductible | |
|---|---|---|---|
| $3,772 | | $5,842 | |
| - 1,132 | Part A deductible | - 1,132 | Part A deductible |
| 2,640 | Remaining | 4,710 | Remaining |
| - 2,612 | Additional charges | -2,612 | Additional charges |
| 28 | Remaining | 2,098 | Remaining |
| - 400 | 1/7 charges | - 28 | Father's debt balance |
| | | $2,070 | Remaining |

Father is authorized on 1/7 with a deductible balance of $1,132. Child's remaining deductible balance on 1/7 is $2,070.

**(III.B.)**

4. Applying Inpatient Charges of a Budget Unit (B.U.) Member Who Is Not an A/R (Refer to B.1.f. to determine if this applies.)

   a. Apply inpatient bills of a b.u. member who is not an a/r on a daily basis as they are incurred.

   b. If the inpatient bills were incurred prior to the certification period, follow instructions in A.1.

**C. Documentation and Verification**

1. Document charges applied to the current Medicaid deductible on DMA-5036, Record of Medical Expenses Applied to the Deductible (see Figure 1). 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.

   a. Document the following for all medical bills, except inpatient hospital bills of an individual incurred during the current c.p.:

      (1) Date of service

      (2) Type of service

      (3) Amount of total charges

   b. 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.

   c. In addition to items in a. and b., above for medical bills, including hospital bills, incurred prior to the current c.p. document the following:

      (1) Status of bill (whether paid or unpaid). If paid by a loan, refer to V. for procedures regarding loans to pay medical expenses.

      (2) Amount applied to deductible

      (3) Amount of unpaid balance

      (4) Date of verification of the unpaid balance

2. Sources of Verification

   a. Verify medical expenses by seeing the bills and statement in the client's possession or

**05/01/02**

**(III.C.2)**

b. Complete the DMA-5037, Medical Provider Verification Form; see Figure 2 for each identified medical provider. The a/r may assume responsibility for obtaining provider verification, but IMC must assist if 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. Authorization and Reporting of Deductible Balance**

1. 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 B.

2. 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 A.1.)

(3) Send 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.

**(III.D.2.b.)**

(2) If an override of the time limit for filing claims is needed, refer to MA-3530, Corrective Actions and Responsibility for Errors, for procedures.

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

3. 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.

4. 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 A. 1.

5. Determining the Deductible Balance**{** XE "Deductible Balance" **}**

a. 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.

b. If the deductible is met during inpatient hospitalization or PRTF stay, the deductible balance is the amount the a/r must pay. It is reported to the hospital or PRTF as the liability on the DMA-5020, and must be the same as the deductible balance entered in EIS. Follow the policy in B. to determine the deductible balance.

6. Case Authorization (See EIS USERS MANUAL)

a. 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.

(1) If the deductible is met due to the a/r's inpatient hospitalization or PRTF stay, 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 B.1. and 2.)

(2) If an inpatient hospitalization or PRTF admission 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.

b. Do not report a deductible balance in EIS when the deductible was met using old bills on the first day of the c.p.

**(III.D.)**

7. Notify the Food Stamp Section when the a/r meets a Medicaid deductible by copy of DMA-5036, Record of Medical Expenses, and the DSS-8194, Income Maintenance Transmittal Form.

## IV. THIRD PARTY RESPONSIBILITY

A medical expense paid by a third party other than the a/r or a current b.u. member may not be applied to the Medicaid deductible, EXCEPT hospital bills (see III.B.) and a medical expense paid by a public program of state, county, or city government (see D., and Figure 3).

### A. Bills For Which There Is Third Party Responsibility

1. Do not count a medical expense that anyone, other than the a/r or an individual 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 D. and Figure 3.

2. Do not count unpaid medical bills from a prior c.p. for which Medicaid eligibility is pending or under appeal. If the pending or appealed case is ultimately denied, the bills may be applied in a subsequent c.p.(s).

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 be 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 B.)

### B. Private Insurance

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. For hospital bills of an a/r, refer to III.B.1.

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.

**(IV.B.2)**

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. Hospital Charges of B.U. Members Who Are Not 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.

(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.

d. 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 B.2.a.

3. When insurance, including Medicaid, has denied the claim because of non-compliance 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:

Failure to provide Medicaid card

Failure to create insurance company questionnaire regarding claim

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

b. Noncompliance DOES NOT include denials that are outside the control of the recipient, such as non-covered services or denials due to failure of the provider 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 day application processing period.

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

**(IV.B.4.a.(1)(a))**

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

2) If the insurance denies due to non-compliance, do not apply the charge to the deductible. (Refer to B.3.)

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

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

(c) Do not hold an application pending beyond 45 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. (Refer to 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 claims 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. Refer to B.3.

(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. Refer to B.3.

(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-3510, Third Party Recovery, and EIS USERS MANUAL.

**C. Medicare**

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

1. Inpatient Hospitalization of Budget Unit Members With Medicare Part A Who Are Not A/R's:

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

(IV.C.1.c.)

been out of the hospital or NF for 60 consecutive days. There is no limit on benefit periods.

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.

(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 (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 the Medicare deductible.

2. Nursing Facility (NF)

If the patient's care is covered by Medicare, he is responsible for coinsurance of $141.50 per day for the 21st through the 100th day, unless the a/r has a "Q" classification showing eligibility for Medicare-Aid (M-QB). 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 $162 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.

(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).

(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.

## D. Public Programs

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.

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

**E. Verification**

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 IV.B.3.)

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.

## V. LOANS

**A. 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**

1. The medical bill meets the requirements in III.A.1. 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.

2. To verify the unpaid loan balance:

   a. Financial Institutions

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

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

b. 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.

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

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

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

c. 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.

4. If the amount of the loan applied to the deductible as determined in V.A.3. is equal to or greater than the amount of the deductible, any excess remaining after additional payments during the c.p. can be carried forward to subsequent c.p.'s as provided in III.A.1.b. If payments on the loan during the c.p. reduce the unpaid balance to $0, there is nothing to carry forward.

5. 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 V.A.3.

6. 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.

7. Examples:

a. 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 charges of $2,250 that were 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.

b. 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.

c. 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 all he still owes.

**MA-3315 FIGURE 4 – DRG GUIDE**