Indiana Health Coverage Program Policy Manual
Chapter 3600 BENEFIT ISSUANCE Sections 3600.00.00 – 3618.20.00

Contents

3600.00.00 BENEFIT ISSUANCE....1

3605.00.00 REPRESENTATIVES AND PROTECTIVE PAYEES....1

3605.05.05 WITHDRAWAL OF AUTHORIZATION....1

3605.05.15.05 EVIDENCE OF MISREPRESENTATION....1

3605.20.00 AUTHORIZED REPRESENTATIVE FOR MEDICAID ELIGIBILITY....1

3615.00.00 MA IDENTIFICATION CARDS....1

3615.10.00 MEDICAID IDENTIFICATION CARDS (MED)....2

3615.10.05 ISSUANCE OF MEDICAID CARDS (MED)....2

3615.10.05.05 ISSUANCE OF MEDICAID CARDS TO HOMELESS INDIVIDUALS (MED)....2

3615.10.10 REPLACEMENT OF ID CARDS (MED)....2

3618.00.00 THE PROCESS OF SATISFYING SPEND-DOWN (MED 1)....3

3618.05.00 NON-CLAIMS SUBMITTED TO DFR (MED 1)....3

3618.10.00 DISALLOWED NON-CLAIMS (MED 1)....3

3618.15.00 MEDICAID HCBS LIABILITY SUMMARY NOTICE (MED 1)....3

3618.20.00 MEMBER SERVICES (MED 1)....4

3600.00.00 BENEFIT ISSUANCE

This chapter presents policy regarding benefit issuance. The chapter covers MA Identification Cards (Section 3615).

3605.00.00 REPRESENTATIVES AND PROTECTIVE PAYEES

As of June 1, 2014, this section no longer applies.

3605.05.05 WITHDRAWAL OF AUTHORIZATION

The authorized representative authorization is valid until the member withdrawals the authorization. The payee or another responsible AG member may withdraw the authorization at any time. Withdrawal of authorization will be made upon request in writing for Medicaid. Written requests will be placed in the case record.

3605.05.15.05 EVIDENCE OF MISREPRESENTATION

When evidence is obtained that an authorized representative has misrepresented an individual's circumstances and has knowingly provided false information the representative may be disqualified from participating as an authorized representative. This disqualification may be for a period of up to one year.

A written notice must be sent to the affected AG and the authorized representative 30 days prior to the date of disqualification. This notification must include:

- The proposed action
- The reason for the action
- The AG's right to request a fair hearing
- The telephone number of the local office (1-800-403-0864).

Disqualification of representatives does not apply in the case of drug/alcohol treatment centers and those group facilities which act as authorized representatives for their residents. In these instances, the facility is liable for any over-issuance which may occur.

3605.20.00 AUTHORIZED REPRESENTATIVE FOR MEDICAID ELIGIBILITY

If the recipient has authorized in writing a representative to apply for MA on his behalf, that representative may also provide verification of incurred medical expenses without a separate authorization. The signed authorization may be time limited or indefinite.

3615.00.00 MA IDENTIFICATION CARDS

Section 3615.10.00 discusses identification cards.

3615.10.00 MEDICAID IDENTIFICATION CARDS (MED)

The Medicaid Identification Card also known as the Hoosier Health Card is the authorization by which the individual secures Medicaid benefits. The card is a permanent plastic ID card expected to be retained by the recipient during his/her lifetime. It contains the Recipient ID (RID) number, name, date of birth, and sex. The ID card does not denote a specific eligibility period.

The recipient must present the ID card to each Medicaid provider from whom he requests medical services, and the provider is responsible for verifying eligibility through the automated verification process. DFR is not responsible for verifying recipient eligibility periods for providers. Providers are responsible for either seeing the ID card or obtaining the RID from the recipient and verifying eligibility to file their claims for services. If there is a delay or problem in the generation of the ID card, DFR should provide the RID to the recipient or to providers who inquire.

3615.10.05 ISSUANCE OF MEDICAID CARDS (MED)

From the date a new recipient is first approved and authorized, it will take approximately two weeks for the recipient to receive the card. Generally, within four days of authorization, IQMA will reflect the generation of the card. It then takes an additional three days to produce the card and at least another three days for mailing. If, after four days from the date of authorization, IQMA does not show the card generation, the Policy Answer Line should be contacted. Individuals who are eligible for Medicaid under the spend-down provision will receive an ID card the same as non-spend-down recipients. However, their eligibility is determined on a month-by-month basis in accordance with Section 3615.15.05.

3615.10.05.05 ISSUANCE OF MEDICAID CARDS TO HOMELESS INDIVIDUALS (MED)

For a recipient who has no fixed address, specific arrangements must be made with him regarding the issuance of his Medicaid card. The card will be mailed to the address specified by the recipient, such as:

- The local DFR office
- A friend or relative
- Social service agency
- Church
- Shelter for the homeless.

3615.10.10 REPLACEMENT OF ID CARDS (MED)

A Medicaid ID Card which has been lost, stolen, or damaged can be replaced by accessing screen BIMD. However, a replacement cannot be requested if IQMA does not show that an original card has been generated. Before requesting a replacement, it is necessary to wait a full seven

days from the date on IQMA indicating card generation. This allows the appropriate length of time to produce and mail the card. If, within the full seven days, the client still has not received the card, the worker must check the recipient's address on AEICI or AEIII as appropriate, and make sure it is entered correctly before requesting a replacement.

3618.00.00 THE PROCESS OF SATISFYING SPEND-DOWN (MED 1)

Effective June 1, 2014, this section is no longer applicable except for individuals covered by the End State Renal Disease (ESRD) waiver. For more information on ESRD, see 3375.00.00.

3618.05.00 NON-CLAIMS SUBMITTED TO DFR (MED 1)

As of June 1, 2014, this section no longer applies.

3618.10.00 DISALLOWED NON-CLAIMS (MED 1)

As of June 1, 2014, this section no longer applies.

3618.15.00 MEDICAID HCBS LIABILITY SUMMARY NOTICE (MED 1)

On the second business day of every month the Core MMIS system generates the monthly Medicaid HCBS Liability Summary Notice. A notice will be issued to every liability recipient for whom claims were applied to the liability during the month. A copy of the notice will be sent to the member and any authorized representatives. In the case of a recipient couple, each member of the couple will receive a notice. More than one month of claims activity may be listed on the notice. The notice reports claims processed during the month without regard to the date(s) of the service.

The Medicaid HCBS Liability Summary Notice is a very important document for liability recipients. The notice informs them of how and to what services their waiver liability was applied. The notice informs them of the amount of their waiver liability that they owe to each medical provider. Except for pharmacies, medical providers may not collect payment from their waiver liability patients, until the patient is notified via the Medicaid HCBS Liability Summary Notice of the amount of the bill that was applied to the patient's waiver liability. Because of the point of service billing device used by pharmacies to submit Medicaid claims, they know the amount of the waiver liability that was credited to their claim when the prescription is dispensed.

DFR staff should stress to recipients and their authorized representatives the importance of retaining these notices. The notices are important for the client's personal record keeping. If recipients have questions about a certain amount that is shown as being owed to a certain provider, they should contact the provider first. Providers are notified via a weekly Remittance Advice (RA) statement of how much of a waiver liability was applied to their claim. The provider's notification and the recipients should match.

If questions cannot be resolved with the provider, the recipient should contact Member Services. DFR does not receive copies of the Medicaid HCBS Liability Summary Notice and do not have information available to them that would allow them to answer questions or resolve any problems relative to the information on the Notice. Refer to Section 3618.20.00 regarding Member Services.

Recipients have the right to appeal any information on the Medicaid HCBS Liability Summary Notice with which they do not agree.

3618.20.00 MEMBER SERVICES (MED 1)

DFR staff members are responsible for informing applicants and recipients and their representatives about waiver liability and how the process works. However, specific questions about the Medicaid HCBS Liability Summary Notice and individual Medicaid claims must be addressed to Member Services. For these issues Local DFR Offices are to tell recipients and their representatives to call Member Services at (317)713-9627 or toll-free at (800)457-4584.