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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

An AG may designate an authorized representative to present medical expense verification for Medicaid spend-down eligibility purposes for purposes of submitting non-claims. (Refer to IHCPM 3618.05.00 and 3618.10.00.

The Medicaid spend-down will no longer be in effect on 6/1/2014. The non-claim process will still be applicable, however, for recipients eligible under a HCBS Waiver (see IHCPM Chapter 3300) who have a HCBS Waiver Liability.

3605.05.05 Withdrawal of Authorization

The authorized representative authorization is valid only for the current entitlement period. 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 will include:

- The proposed action;
- The reason for the action;

The AG's right to request a fair hearing; and
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 overissuance which may occur.

3605.20.00 AUTHORIZED REPRESENTATIVE FOR SPEND-DOWN 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. Additionally, the recipient may authorize a different individual to provide medical expense documentation for purposes of submitting non-claims. (Refer to IHCPPM 3618.05.00 and 3618.10.00. The signed authorization may be time limited or indefinite.

The Medicaid spend-down will no longer be in effect on 6/1/2014. The non-claim process will still be applicable, however, for recipients eligible under a HCBS Waiver (see IHCPPM Chapter 3300) who have a HCBS Waiver Liability.

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 in order 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; or
- 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, MED 2)

Effective June 1, 2014, this section is no longer applicable for MED 1.

This section applies to MA A, MA B, MA D and MA Q.

The spend-down process works basically like an insurance deductible. Recipients have access to Medicaid covered services at the first of every month in which they are enrolled. Medicaid will reimburse claims once the spend-down amount is satisfied.

Providers will submit recipient claims to IndianaAIM just as they do for all fee-for-service members. The spend-down amount will be applied to claims for Medicaid covered services and will be deducted from the amount, if any, that Medicaid reimburses on the claim. For example, a recipient with a \$50 spend-down goes to his pharmacy to get his prescription refilled. The cost of the prescription is \$75 and the Medicaid co-payment is \$3. The member is responsible for \$50, which includes the Medicaid co-payment, and Medicaid covers the remainder in accordance with Medicaid reimbursement rules. Later in the month, his doctor gives him a new prescription which he takes to the pharmacy. Because his spend-down is already satisfied, Medicaid reimburses the pharmacy. The recipient owes the \$3.00 co-pay and it will be automatically carried forward to the next month to satisfy spend-down. Certain allowable medical expenses cannot be filed as claims directly to IndianaAIM. These expenses are referred to as non-claims and must be submitted to the Local Division of Family Resources Office. Refer to Section 3618.05.00 which explains how non-claims are to be considered. These expenses are transmitted electronically to AIM to satisfy spend-down.

Providers must first bill any third party insurance of the recipient before billing Medicaid. A medical expense that is subject to payment by a third party will not be considered for satisfying spend-down until the third party adjudicates the claim. The amount that can credit spend-

down is the amount owed by the recipient after the third party payment. For recipients who also have QMB (MA L) coverage, their Medicare coinsurance and deductibles will not credit spend-down, since QMB Medicaid pays those costs.

The Medicaid spend-down for MA A, MA B, and MA D will no longer be in effect as of June 1, 2014.

3618.05.00 NON-CLAIMS SUBMITTED TO DFR (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

Certain medical expenses apply to spend-down and must be submitted to the DFR because they cannot be filed directly by providers to the AIM system. These expenses are called non-claims and are as follows:

1. Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance. For these expenses, documentation from the provider of the service must be submitted and it must contain a statement from the provider that he or she will bill the state or local program, not Medicaid. A state or local program is one which is funded 100% by state or local funds.

Any service which is paid for by the CHOICE program must be an allowable medical expense in order for the expense to be entered as a non-claim and allowed to satisfy spend-down. For example, home health care provided by a licensed home health agency is an allowable expense. However, in addition to medical home health care, the CHOICE program pays for non-medical in-home services that can't be used to satisfy spend-down. Therefore, specific documentation is required in order to allow a non-claim for an expense that the provider will bill to CHOICE. The documentation from the provider must list the specific service provided and the procedure code. The allowable home health services and their procedure codes are listed below:

Licensed Home Health Aide	99600
Registered Nurse (RN)	99600TD
Licensed Practical Nurse (LPN)	99600TE
Physical Therapy	G0151
Occupational Therapy	G0152
Speech Therapy	G0153

This information is required in order for the services to be correctly considered for spend-down. If the documentation presented lists other service types or procedure codes for home health services, the expense must be entered as a disallowed non-claim.

Documentation submitted from providers must indicate that the services will be billed to CHOICE, not Medicaid. If this statement does not appear on the bill/statement, the expense is not allowed. The preferred documentation is a copy of the provider's invoice to the Area Agency on Aging.

2. Medical services received from a provider who does not participate in the Medicaid program. DFR must contact the provider and verify that s/he is not a Medicaid provider if that information is not documented on the bill/receipt received by the DFR.
3. Medical services received by non-recipient spouses and parents whose income was used to determine the spend-down.
4. Bills for medical services received before the recipient became eligible for Medicaid.
5. Co-payments required by other insurance coverage and Medicare.

A non-claim will be applied to spend-down in the month following the month the DFR receives the receipt/bill, unless the recipient wants it to be applied to the month of the medical service or to the month the expense is submitted to the DFR. DFR must maintain fail-safe controls that ensure that no non-claim expense is ever counted for spend-down more than once. Hard copies of the documentation must be retained subject to regular record retention rules.

All expenses that the DFR receives must be entered in ICES except a bill for a service that should be filed as a claim to Medicaid. These are not non-claims and the DFR must notify the provider (if faxed to the DFR) or the recipient of the proper procedure to follow.

Allowable Medical Expenses:¹

Listed below are the types of medical expenses that can credit spend-down. Medical services of the recipient must be billed to the AIM system except in the circumstances described above for non-claims. At the end of this section are verification requirements for non-claims.

1. Medical care provided by physicians, psychiatrists, and other licensed medical practitioners;
2. Laboratory testing, x-rays, and other diagnostic procedures;
3. Dental services including dentures provided by a licensed dentist;
4. Hospitalization and outpatient treatment;
5. Nursing facility services and rehabilitative services;
6. Respiratory, occupational, speech, physical, and audiology therapy services;
7. Prescription drugs and over the counter medication (including insulin) when prescribed by a licensed medical practitioner who is authorized under State law to prescribe legend drugs. For Medicare beneficiaries, this includes drugs that are excluded from coverage under Medicare Rx. Excluded drugs **include** barbiturates, benzodiazepines, and over-the-counter drugs that are Medicaid covered. A Prescription Drug Plan may choose to cover a Medicare excluded drug, in which case the cost of the drug is not an allowable medical expense in the Medicaid budget. An excluded drug under Medicare Rx is different from a non-formulary drug. Refer to 3618.05 for a list of non-allowed medical expenses.
8. The cost of postage incurred by the individual for mail-order prescriptions;
9. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition;

¹ 405 IAC 2-3-10

10. Durable medical equipment if ordered in writing by a licensed physician;
11. Home health care provided by a licensed home health agency;
12. Nursing services provided by a registered nurse or licensed practical nurse;
13. Audiology services and hearing aids if ordered in writing by a physician;
14. Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist;
15. Vision care services, including eyeglasses, examinations, and diagnostic procedures;
16. Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. If the individual or friend, or family member drives the individual to medical services, mileage costs is allowed at the rate per mile established for state employee business travel. The state employee business travel rate of \$0.40 will be allowed for medically-related transportation expenses incurred on or after 10-1-09. (If incurred 7-1-08 through 9-30-09, the allowed amount was \$0.44 per mile; if incurred prior to 7-1-08, the allowed amount was \$0.40 per mile.)
17. The premium of the recipient's spouse who is on MED Works (MADW);
18. Co-payments required by other health insurance that covers the individual, including Medicare Rx co-payments. The Medicaid co-payments are allowable medical expenses when the recipient is satisfying spend-down and will be credited to spend-down by the AIM system when the claim is filed by the provider.
19. Any waiver service approved for the individual who is approved under one of the Medicaid Home and Community-Based Services (HCBS)

20. Targeted case management services provided to pregnant women, individuals with HIV, and individuals receiving services from a community mental health center under the Medicaid rehabilitation option.

VERIFICATION OF NON-CLAIM MEDICAL EXPENSES:

Verification of non-claim medical expenses will include the type and amount of the expense, the date the expense is incurred, whether or not it is reimbursable by a third party, and the reimbursed amount. Medical expenses and third party reimbursed amounts can be verified by the following:

- Bill from a provider;
- Receipt from a provider;
- Written statement from a provider; and/or
- Telephone contact with the provider, as a last resort.

Verification must show whether a third party has or will be billed, and if a third party has paid, the amount of the payment must be shown so that the DFR staff can determine the individual's out-of-pocket expense.

Medicare or other insurance reimbursement can also be verified by the Medicare Summary Notices that Medicare sends to beneficiaries and other explanation of benefit notices from insurance payers.

For transportation expenses incurred from a non-business carrier, a record of the provider's name, address and date of service for the expense must be provided. MapQuest or similar website can be used by the DFR staff to determine the distance traveled.

3618.10.00 DISALLOWED NON-CLAIMS (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

If an expense is subject to payment by a third party that has not yet adjudicated the claim, the expense is to be entered into the system as disallowed. DFR staff must follow the ICES data entry procedures very carefully. This will ensure that proper information is given to the recipient on the monthly Spend-down Summary Notice. If the third party has adjudicated the claim when it is submitted to the DFR, the portion that the individual owes, the out-of-pocket cost is the allowable amount.

Non-allowed expenses include the following and will not credit spend-down:

1. Special diets and nutritional supplements.
2. Emergency response systems.
3. Non-medical home care such as companions, attendants, homemakers, etc.
4. Home and vehicle repairs/modifications to accommodate a handicapped individual.
5. For Medicare beneficiaries, drugs that are not on the Prescription Drug Plan's formulary.

Non-allowed claims will be listed on the Spend-down Summary Notice as not being applied to spend-down.

3618.15.00 SPEND-DOWN SUMMARY NOTICE (MED 1, MED 2)

On the second business day of every month the IndianaAIM system generates the monthly Spend-down Summary Notices. A notice will be issued to every spend-down recipient for whom claims or non-claims were applied to spend-down during the month. A copy of the notice will be sent to 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 and non-claims processed during the month without regard to the date(s) of the service.

The Spend-down Summary Notice is a very important document for spend-down recipients. The notice informs them of how and to what services their spend-down was applied. The notice informs them of the amount of their spend-down that they owe to each medical provider. Except for pharmacies, medical providers may not collect payment from their spend-down patients, until the patient is notified via the Spend-down Summary Notice of the amount of the bill that was applied to the patient's spend-down. Because of the point of service billing device used by pharmacies to submit Medicaid claims, they know the amount of the spend-down 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 spend-down was applied to their claim. The provider's notification and the recipient's should match. If questions cannot be resolved with the provider, the recipient should contact Member Services. DFR does not receive copies of the Spend-down Summary Notices 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 Spend-down Summary Notice with which they do not agree.

3618.20.00 MEMBER SERVICES (MED 1, MED 2)

DFR staff members are responsible for informing applicants and recipients and their representatives about spend-down and how the process works. However, specific questions about the Spend-down 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.