TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF ELIGIBILITY SERVICES
DIVISION OF ELIGIBILITY POLICY/MCHP
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201
410-767-1463 or 1-800-492-5231 option 2 and request extension 1463

MANUAL: Medical Assistance **EFFECTIVE DATE: Immediately**

RELEASE NO: MR-157 **ISSUED: October 2013**

APPLICABILITY: Revised Policy Alert 10-12

Item	**Replacement Pages**
Chapter 10 – Eligibility for Institutionalized Persons	1000-35 – 1000-36 (Revised 12/05)
Deduction of Non-Covered Medical or Remedial Services From an Institutionalized Person's Available Income for the Cost of Care	Policy Alert 10-12 (Revised 10/13)
OES 001 Revised 8/12 – Request for Non-Covered Services	Form OES 001
Post-Eligibility Deductions	(Revised 8/12)

COMMENTS

IMPORTANT: THE ATTACHED REVISIONS HAVE NOT BEEN INCORPORATED IN THE ONLINE MEDICAL ASSISTANCE MANUAL.

Non-Covered Services

Manual Release MR-157 revises:

- Policy Alert 10-12
- Medical Assistance Manual Chapter 10, pages 1000-35 – 1000-36
- Form OES 001

Effective July 1, 2011, the MA-LTC application and redetermination forms 9709 and 9709R were revised to include the Declaration of Pre-Eligibility Medical Expenses. Therefore, Form OES 010 is obsolete. The OES 011 (LTC) is still in use.

For questions about these policies or procedures, contact the DHMH Division of Eligibility Policy and Training at 410-767-1463 or 1-800-492-5231 (option 2, extension 1463).

Medical Care or Remedial Service

Non-covered services: This is an allowance for those medical or remedial items or services that are recognized under State law but not covered by the State Plan. These include expenses for items such as dentures, hearing aids and prosthetic devices, or services from dentists or audiologists. Refer to Appendix II in Chapter 9 for a more extensive list of items and services not covered by the Medicaid State Plan. These expenses are usually documented by a bill or a paid receipt.

An eligible MA-LTC recipient may be in need of an item such as dentures or eyeglasses, but unable to obtain it without giving the provider a guarantee of payment. A written and signed contract with the provider that obligates the person to pay in a lump-sum or by installments is acceptable documentation to allow the deduction from the recipient's available income.

Pre-eligibility medical expenses: For a Medicaid application, a deduction from available income for cost of care may be made for medical or remedial services covered by Medicaid (e.g., nursing facility) but not covered for the **recipient because the recipient was not Medicaid eligible as of the service date**. The recipient's incurred expenses may only be deducted if the services were received during any months in the three-month period prior to the month of **the current** Medicaid application, in which the recipient was determined not Medicaid eligible**. Incurred expenses may also be deducted for any months that the recipient was ineligible between the month of the current application and the effective date of Medicaid eligibility.** The bill must have been unpaid and remained the recipient's obligation to pay at the date of application, as verified by a detailed bill or statement from the provider. Bills for medical or remedial services received before the three-month period may **not** be deducted from the recipient's available income for the cost of care.

For unpaid nursing facility bills incurred during a penalty period resulting from a transfer of assets for less than fair market value, the amount deducted is $0.

Amount of deduction: For services received during ineligible months, the provider's charge is deducted. For non-covered services received **when the recipient is MA eligible, the lesser** of the provider's charge or the Medicaid fee is deducted. If a Medicaid fee is not established, the provider's charge is deducted.

When deduction is applied: Requests for pre-eligibility medical expenses submitted at the time of the MA-LTC application will be deducted **beginning in the first month of eligibility**. Requests for non-covered services submitted during periods of eligibility will be deducted beginning the month the request and required documentation were submitted, as this is an interim change. The deduction, when added to all other deductions, may not exceed the recipient's total countable income for the month.

To determine the allowable deduction, the case manager (CM) sends a **completed** OES 001, a self-addressed envelope, **a copy of the CARES STAT Screen for all denied months, and a copy of the detailed current bill, receipt, or contract to:**

DHMH
201 West Preston Street, Rm. SS-10
Baltimore, MD 21201
Attn: Non-Covered Services

The bill, receipt, or contract must contain:

1. The provider's name, address and telephone number;
2. The name of the A/R who received the service(s);
3. The service date(s);
4. The amount(s) charged:
    - Per service,
    - Per date; and
5. Detailed description of the item or service; and
6. Applicable procedure code(s) for each service for:
    - Dental services,
    - Podiatry services,
    - Audiology services,
    - Vision services; and
7. All payments received by the provider for the charges billed.

For services already furnished and billed to an A/R, the CM must request documentation of any payments applied to the charges billed.

If an A/R is a Medicare recipient or has another insurer, the bill will not be considered until it is verified what portion is paid or denied by Medicare or other insurance.

Every "Request for Non-Covered Services Pre/Post-Eligibility Deductions" (Form OES 001) that a CM forwards to DHMH must be supported by bills, receipts, or contract that contain the required information listed above. If an A/R submits a request for non-covered services without documentation or with unacceptable bills, receipts, or contract, the CM returns the unacceptable bills, receipts, or contract to the A/R and request the specific documentation required.

DHMH will review the request and send the CM a memo with the allowable amount noted along with the A/R's Non-Covered Service Report.

- To be deductible, expenses cannot be covered by Medicaid, Medicare, any other health insurance, or 3rd party payment (e.g., long-term care insurance, disability insurance).

- Except in the case of pre-eligibility medical expenses, this allowance may not be given to reimburse a relative or someone else who has already paid the bill.
- A deduction is not made for medical or remedial services received before the 3-month period prior to application.
- Since the deduction is only made for medical or remedial services, any extraneous charges such as for the barber/beauty parlor, TV rental, social activities such as movie nights, ice cream socials, wine tastings, dinner guests, or personal items are not allowed.
- The deduction may not include services covered by Medicaid that were received when the recipient was Medicaid-eligible, but for which the Program denied payment because the services were not medically necessary, were not authorized, were not provided by an enrolled and qualified provider, **or were billed after the 12-month billing limitation.**
- If there is a contract for regular payments for an item or service, the monthly obligation may be allowed for the period specified in the contract.
- If the amount of the medical expense, in addition to other allowable deductions, exceeds the recipient's total countable income for the month, the excess portion of the deduction for the medical expense may be carried forward to the ongoing month(s) and, if necessary, may be carried forward into a subsequent 6-month period under consideration.
- The CM should set a "745" alert in CARES to recalculate the recipient's available income as of the month that the deduction is scheduled to end.

There are no deductions from total income except those listed above. If total deductions for a month are greater than or equal to the recipient's total countable monthly income, the person's available income is $0. With the exception of medical care or remedial services, as specified above, deductions in excess of total countable income are not carried forward to subsequent months. If total deductions are less than the total income for the month, the amount remaining after these deductions is the available income.

Cost of Care

For current eligibility, determine average monthly cost of care by multiplying the private per diem rate by 30.3.

For retroactive eligibility, determine monthly cost of care by multiplying the actual number of days in each month that are not subject to third party payment or reimbursement by the private per diem rate.

Eligibility Determination and Certification

To determine current eligibility, compare the monthly available income to the average monthly cost of care.

To determine retroactive eligibility, compare the actual monthly available income for each month to the actual cost of care for each retroactive month.

Policy Alert 10-12

Deduction of Non-covered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care

Certain deductions are allowed when calculating an institutionalized person's available income for the cost of care in a long-term care (LTC) facility or waiver program. One of the allowable deductions is for the individual's unpaid, incurred expenses for necessary services recognized under State law as medical or remedial care but not covered by the State's Medical Assistance (Medicaid) program.

In two circumstances, non-covered services may be used as a deduction from a recipient's contribution towards the cost of care (patient resource amount):

A. The individual was enrolled as a Medicaid LTC or waiver recipient for the date of service, but the necessary medical or remedial services are not covered under the Medicaid State Plan.

For example, services that are only covered by Maryland Medicaid for children younger than 21 years old (e.g. private duty nursing, eyeglasses, dental care, dentures, or hearing aids) may be deducted from an adult LTC or waiver recipient's available income for the cost of care. Deductions for non-covered assisted living services may not include room and board, just expenditures for the types of medical or remedial services covered for waiver enrollees

B. The recipient is not Medicaid-eligible for the service date, and the service was received:

- During the three-month period prior to the month of the current application; or
- During any period between the month **of the current application** and the first month of current eligibility.

For example, unpaid bills for nursing facility services received by a recipient during ineligible months in the three month period prior to the month of the current application (e.g., when the recipient was still resource over scale) may be deducted from the recipient's available income for the cost of care.

Note: Although there is no retroactive period associated with a waiver application, waiver applicants residing in Assisted Living Facilities are entitled to have unpaid medical bills incurred during the three months prior to the month of the current application deducted from their available income for the cost of care.

1. When the applicant or authorized representative indicate they have unpaid medical bills at application, first the CM determines the A/R's eligibility for Medicaid Long Term Care (MA-LTC). ***Note: If the A/R indicates they have unpaid medical bills at application that were incurred in the last three months, an eligibility determination must be made for these months prior to sending a request to DHMH to determine any pre/post- eligibility medical expense deductions.***

2. When the recipient or authorized representative indicates they have unpaid medical bills at redetermination, first the CM redetermines eligibility for Medicaid Long Term Care (MA-LTC).

3. As soon as the A/R is determined eligible, the CM requests and/or collects the bills from the applicant/authorized representative and then:

a) Verifies that the items or services:

- Occurs during one of the two time periods in section B above;
- As of the first day of the month of application the bill must have been unpaid and remained obligation of the applicant/recipient (A/R) to pay, as verified by a detailed bill, or statement from the provider. Bills for medical or remedial services received prior to the three-month period may not be deducted from the recipient's available income for the cost of care;
- The dates of service are not more than three months prior to application;
- Are recognized under Maryland law as a medical or remedial service; and
- Were medically necessary (e.g. would be reimbursed by Maryland Medicaid if the individual and/or service were covered).

b) Requests the necessary verifications. The provider's bill, invoice or statement must:

- Be an itemized bill, statement , contract or invoice, for items or services furnished during the three months prior to the application month or for an ineligible month between the application month and the first month of current eligibility;
- Specify the date(s) of service;
- Describe the services received in detail, **including procedure codes** when applicable;
- Specify the provider's charge for each service received (e.g. give separate charges for nursing facility services and for non-medical services such as beauty parlor/barber services, cable, telephone or security alarms and monitors);
- Specify any payments received or third party liability for the services (e.g. payments from the A/R or others on the A/R's behalf prior to the month of application, and any third party payments from health insurance, Medicare, LTC insurance, etc.); and
- Give the provider's name, address, and telephone number.

4. To determine the allowable deduction, the CM must complete all fields on the OES 001 and send a copy of the CARES STAT Screen for all denied months, and a copy of the detailed current bill, invoice or contract to:

   DHMH
   Attn: Non-Covered Services
   201 West Preston Street, Room SS-10
   Baltimore, MD 21201

5. When the CM receives DHMH's approval to deduct a specified total amount for the non-covered services, the CM manually calculates the A/R's available income for the cost of care, to assure that it is calculated correctly. Use the DHMH 1159 (LTC) Worksheet for

Institutionalized Persons- Cost of Care/Available Income. Enter the allowable deduction for non-covered services as "Other" under deductions on the worksheet.

- If the amount approved by DHMH for the non-covered service deduction *is less than* the A/R's monthly available income without the non-covered service deduction, use the amount approved by DHMH as the deduction.

- If the non-covered service deduction approved by DHMH *exceeds* the A/R's monthly available income, use the A/R's monthly available income without the non-covered service deduction as the monthly deduction for the non-covered services. Then, the available income is reduced to $0. All of the A/R's net countable income, after any other deductions are subtracted (e.g. spousal maintenance allowance, personal needs allow*ance),* is allowed as the deduction for non-covered services, so that the recipient may pay the provider's bill in full as quickly as possible.

- Complete more than one column on the DHMH 1159D worksheet if you expect a change in income, cost of care, or deductions- e.g., the recipient's income will change due to a cost of living increase, or the deduction for Medicare premiums will end in the 3rd month of Medicaid eligibility when Medicare Buy-In begins.

- Estimate how many months the deduction for non-covered services will continue until the monthly deductions total the deduction approval by DHMH. Establish a way (e.g. CARES "745" alerts, tracking system) to assure that the monthly deductions continue until the total is reached, and that the monthly amount is adjusted as necessary when the recipient's net countable income and/or other deductions change over time.

6. Enter the required information onto the INST screen of CARES. The monthly deduction for non-covered services is entered in the field for "UNCVRD MED AMT". Complete the INST screen for the current month, any ongoing month with a change, and any historic month with a change.

7. Check the MAFI screen of CARES for each impacted month to assure that it has the correct information and calculations. Make any necessary corrections to assure that the available income is correct on CARES for each month, and will transmit correctly to MMIS recipient screen 4 as the "patient resource amount". The line for "Non-covered Med Exp" on the MAFI screen represents the sum of three fields from the INST screen: "UNCVRD MED AMT" for the non-covered services, "MEDB PREM AMT" for non-covered Medicare premiums, and "UNCOVERED INS PREMIUM AMT" for other non-covered insurance premiums.

8. If a change or correction is necessary to MMIS Recipient Screen 4 that cannot be processed through the CARES-MMIS interface, submit the 206C form to the DHMH LTC Reconciliation Unit (e.g. to change the available income/resource amount for one or more historic months).

9. Suppress the CARES notice. Issue the manual DHMH 4240 (LTC) Notice of Change in Available Income and OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction to the recipient, any designated representative and the LTC facility (if the consent to release of information is signed). Complete the DHMH 4240 (use additional notices as necessary) to inform the recipient of the allowed deductions and the available income for the current month and for any subsequent months with a

change. Under "other" specify the allowable deduction. Attach to the OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction a copy of the A/R's Non-Covered Service Report sent by DHMH.

10. Set a "745" alert in CARES as a reminder to recalculate the recipient's available income for any anticipated change in the recipient's income (e.g. January 1st COLA increase in Social Security income) or other deductions (e.g. annual increase in health insurance premium or the community spouse's rent). Also, set a "745" alert for the date the deduction for non-covered services is estimated to end, i.e. when the full amount approved by DHMH will have been deducted.

11. Fully narrate in CARES. Include the requested amount of non-covered service deduction, the amount approved by DHMH, the type of service, the provider, and the anticipated ending month for the deduction.

12. If the recipient's income or a deduction changes, follow the above procedures for manual calculation of the non-covered service deduction and the available income and for entry into CARES. Suppress the CARES notice and send the manual DHMH 4240 (LTC) Notice of Change in Available Income to recipient, any designated representative, and the LTC facility.

Time Frame for Deducting Non-covered Services from a Recipient's Available Income for the Cost of Care in a LTC Facility or Waiver

- The deduction may not begin before the month that the expense is incurred by the recipient.
- When an applicant indicates they have pre-eligibility medical expenses and acceptable documentation is provided (bills, receipts, contract), the CM submits the OES 001 Request for Non-Covered Services to DHMH if the applicant is found eligible. If a deduction is approved by DHMH, the CM allows the deduction beginning in the first month of eligibility.
- When a recipient requests a deduction for non-covered services during periods of eligibility, the CM must immediately submit the request to DHMH. If DHMH approves a deduction, the CM begins the deduction the month the request and required documentation were submitted, as this is an interim change.
- If there is a contract for regular payments for an item or service, the monthly obligation may be allowed for the period specified in the contract.
- If the non-covered service deduction request approved by DHMH, after allowing other deductions, exceeds the recipient's net countable income for the month, the excess portion of the deduction for non-covered services may be carried forward into additional month(s). If necessary, it may be carried into subsequent 6-month period(s) under consideration. The deductions continue until the monthly amounts deducted for the non-covered service total the amount approved by DHMH for the deduction.
- Unpaid bills for medical services incurred during the 3 months prior to the month of the current application may be considered for a non-covered service deduction if the bills are for services received during the consideration period associated with an earlier application:
    - that was denied due to a technical factor;

- that was denied due to excess resources; or
- that expired more than six months after the application month.

- If the LTC provider needs to submit a claim more than 12 months after the service date due to agency (DHMH/DHR) delay or a change in the recipient's available income calculated by the agency, the CM sends the DHR/IMA 81 Administrative Error Letter to the provider and a copy to the recipient. The provider submits the DHR/IMA 81 letter with the claim, so that DHMH will not apply the 12-month billing limitation when processing the claim.

Example 1:

Customer files a MA-LTC application January 3, 2010. No information is returned to determine eligibility. On the 30th day the application is denied and notice is sent to all required parties. The application is placed in a preserved status for the remainder of the 6 month consideration period, which ends June 30, 2010. On July 6, 2010, the customer submits a new application for MA-LTC coverage. The customer states that they have unpaid medical bills for 3 months prior to the month of the **new** application. Since these bills were incurred during a **prior expired consideration period**, they cannot be considered for retroactive coverage in connection with the new application. However, the bills must be submitted to DHMH for a determination of the request for deduction of non-covered medical or remedial services.

Example 2:

DHMH approves a deduction of $450 for dental care received by a recipient. According to the MAFI screen for the current month (based on the CM's entries on UINC, ERN1, and ERN2 screens), the recipient's total available income before deducting these non-covered services is $1,400. The recipient has no deductions for Medicare premiums or private health insurance. After the deduction for non-covered dental services, the recipient's available income is reduced to $950. The CM enters $450 under "UNCVRD MED AMT" on the INST screen for the month the request was submitted. The CM checks the MAFI screen for the current month. The CM makes the necessary corrections if MAFI does not have $450 for "Non-covered Med Exp" and $950 for the "Available Income Amt." The CM ensures that the non-covered service is only deducted for the applicable month, not for ongoing months when the available income should return to $1,400. The CM suppresses the CARES change notice and issues the DHMH 4240 (LTC) change notice and the OES 011 (LTC) and DHMH Non-Covered Service Report to the recipient, representative (if applicable) and the LTC facility, to inform them of the recipient's approved deduction for the dental expense and of the change in the recipient's available income for the cost of care for that one month. The CM fully narrates in CARES.

Example 3:

DHMH approves a deduction of $9,000 for nursing facility services received by a newly approved recipient during two ineligible months prior to the month of application. The CM uses the DHMH 1159D work sheet to re-calculate the available income. The recipient has monthly income of $1,400 and deductions for a personal needs allowance of $74, a spousal maintenance allowance of $400, and the Medicare Part B premiums of $96.40 for the first two months of Medicaid eligibility. Therefore, the recipient's available income is $829.60, before deducting nursing facility non-covered services. This means that, for the 1st and 2nd month of current eligibility, the deduction for non-covered services (the unpaid private-pay nursing facility bills)

is $829.60 and the available income is $0. Beginning with the 3rd month of current eligibility, there is no deduction for Medicare premiums. Therefore, the deduction for non-covered services increases to $926.00 and the available income remains at $0. The CM determines that it will take 10 months of non-covered services deductions to total the recipient's incurred expenses for nursing facility services.

The CM enters the information in CARES and suppresses all CARES approval notices and issues the DHMH 4240 (LTC), the OES 011 (LTC) and a copy of the DHMH Non-Covered Service Report to the recipient, representative (if applicable) and the LTC facility. These documents inform them of the eligibility decision, the number of months the non-covered services deduction will be in effect, the available income of $0, and each approved deduction including the monthly deduction for the unpaid nursing facility bill. Two columns are completed on the notice--one for the first two months of eligibility and the second column for the 3rd and ongoing months. The CM fully narrates in CARES.

The CM sets a "745" alert in CARES to recalculate the recipient's available income for the 10th month of eligibility (the last month of deductions for the recipient's nursing facility bills). Also, "745" alerts are established to adjust the deduction amounts and/or available income for any other month that a change to other deductions or income is anticipated. Beginning with the 11th month of eligibility, there will be no deduction for non-covered services. In the 9th month, the CM records the manual calculations on the DHMH 1159D (LTC) worksheet, enters the necessary information on CARES, and issues the manual DHMH 4240 (LTC) change notice with two columns completed for the 10th month and for the 11th and ongoing months. Again the CM sends copies of these forms to the recipient, representative (if applicable) and the LTC facility. The CM narrates in CARES.

Example 4:

A recipient is in the 2nd year of the 20 months necessary to pay off a bill of $12,000 for nursing facility services received during ineligible months in the retroactive period. The recipient's monthly Social Security income is $664. Since the recipient has no deductions besides the personal needs allowance of $74 and the non-covered services, the monthly amount deducted for non-covered services is $590 and the available income is $0.

The CM sets a "745" alert to recalculate the available income when the recipient's Social Security check increases on January 1st. When the CM finds out what the COLA will be (in this example the COLA will be 4.1%, so the recipient's income will increase to $692), they recalculate the deduction for non-covered services as $618 to keep the available income as $0. CARES will automatically issue the COLA letter in early December informing the customer that the available income for the cost of care will be $28. The CM issues the manual DHMH 4240 (LTC) change notice to the recipient, informing them that the deduction for non-covered services is actually $618 and that the available income for the cost of care is still $0.

Note: Remember to use current rates for the Medicare premiums and the personal needs allowance.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231, option 2, extension 1463.

Request for Non-Covered Services Pre/Post-Eligibility Deductions

To: Office of Eligibility Services
Department of Health & Mental Hygiene
201 West Preston Street, Room SS-10
Baltimore, Maryland 21201-2399

Date Received by DHMH

From: _____Local Department of Social Services

_____

_____

D.O. #_____

Date Request Sent_____

Please **complete** the following information: ☐ New Request ☐ Resubmission

Case Manager _____ Contact Number _____

Case Name _____ Client ID Number _____

Application Date _____ Current Certification Period _____

Penalty Period (if applicable) From _____To_____

Retro Period _____

Has an eligibility determination been made for the **retro period**? ☐ Yes ☐ No
(A determination **must** be made for the retro months requested before submitting this form*)

Retro Eligibility Determination

1st Month _____ ☐ Approved Denied ☐

2nd Month _____ ☐ Approved Denied ☐

3rd Month _____ ☐ Approved Denied ☐

Attach a copy of denial notices for all current and retro months. *This does not apply to Waiver cases.

Type of Expense
(Place a check mark next to the appropriate type.)

☐ Dental Bill

☐ Vision Bill

☐ Pharmacy Bill

☐ Other (Please Specify):
_____

☐ Hearing Aid Bill

☐ Podiatry Bill

☐ Nursing Home Bill
Months being requested:
_____

OES 001 (LTC) Revised 08/12 All other versions are obsolete. All information MUST be completed