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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #04-321(F)

DIGEST

Adds 405 IAC 1-1-3.1 to specify the responsibilities of Medicaid providers when providing services to members enrolled under the Medicaid spend-down provision. Amends 405 IAC 2-3-10 to set out the policies and procedures that apply to Medicaid spend-down eligibility. Effective 30 days after filing with the Secretary of State.

405 IAC 1-1-3.1
405 IAC 2-3-10

SECTION 1. 405 IAC 1-1-3.1 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-1-3.1 Providing services to members enrolled under the Medicaid spend-down provision
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-15

Sec. 1. (a) This section applies to a Medicaid-participating provider furnishing services to an individual enrolled in Medicaid under the spend-down provision set out at 405 IAC 2-3-10.

(b) A provider must submit a claim to Medicaid for any service for which Medicaid reimbursement may be available under 405 IAC 5. Such services include services provided in excess of Medicaid benefit limitations. The provider must comply with any prior authorization requirements applicable to the service.

(c) Except for applicable copayments, a provider may not bill a Medicaid member for any part of the provider's charge for a service billed to Medicaid until:
(1) Medicaid has adjudicated the provider's claim for the service; and
(2) the provider has been notified of the portion of the claim that was credited to the Medicaid member's monthly spend-down obligation.
The provider may bill the member for the amount that was credited toward the member's spend-down as well as any unpaid copayment amount due.

(d) A provider may not refuse service to a Medicaid member pending verification that the member's monthly spend-down obligation has been satisfied. A provider may not refuse service to a Medicaid member solely on the basis of the member's spend-down status. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1-3.1; filed Jul 18, 2005, 1:00 p.m.: 28 IR 3579)*

SECTION 2. 405 IAC 2-3-10, AS AMENDED AT 28 IR 178, SECTION 1, IS AMENDED TO READ AS FOLLOWS:

405 IAC 2-3-10 Spend-down eligibility
Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 10. (a) ~~As used in~~ **The following definitions apply throughout** this section: ~~"countable income"~~
(1) "County office" means the county office of the division of family resources of the family and **social services administration.**
(2) "Incurred medical expenses" ~~have~~ **has** the ~~meanings~~ **meaning** set forth in 42 CFR 435.121(f) and ~~section 3 of this rule. For~~

~~purposes of this section, "third party"~~ **subsection (e). The term includes expenses incurred by the applicant's or recipient's spouse or parent whose income is counted in determining the applicant's or recipient's eligibility for Medicaid. The term** does not include **expenses that are subject to payment or have been paid by a third party, except expenses paid by** the following:

~~(1)~~ **(A)** A state program.
~~(2)~~ **(B)** A local program.
~~(3)~~ **(C)** Discounts or assistance received under the Medicare drug discount card and transitional assistance program authorized under 42 U.S.C. 1395w-141.

(3) "Spend-down obligation" means the amount of any excess monthly income remaining in the eligibility determination in section 20(a)(14) of this rule.

(b) ~~Any~~ **In order to be enrolled in Medicaid under the spend-down provision, an** otherwise eligible applicant ~~or recipient whose countable monthly income exceeds the applicable income limit specified in section 18 of this rule is eligible for medical assistance for that part of any month after his or her~~ **must provide documentation to the county office of incurred medical expenses in excess of the spend-down obligation. If the applicant's ongoing** incurred medical expenses ~~equal~~ **do not exceed** his or her excess income, **his or her application will be denied. Medicaid coverage will be approved for any month prior to the denial date in which incurred medical expenses equaled or exceeded the spend-down obligation, if all other eligibility requirements are met for the month. The Medicaid program will reimburse covered services in accordance with 405 IAC 5 for incurred medical expenses in excess of the spend-down obligation.**

(c) ~~In order to be determined eligible for medical assistance under this section, the applicant or recipient must provide to the county department, for each month in which he or she requests medical assistance, documentary verification of his or her~~ Incurred medical expenses ~~for which he or she remains currently liable. The county department will promptly determine the date on which the applicant became eligible for medical assistance and issue the appropriate eligibility documents for the remainder of that month.~~ **will credit the spend-down obligation in the following order and manner:**

(1) Incurred medical expenses submitted to the county office as described in subsections (e) and (f).
(2) Medicaid copayments beginning with the month the service requiring the copayment was incurred and continuing in subsequent months until the full copayment has credited the spend-down obligation.
(3) Medicaid claims filed by Medicaid providers in accordance with 405 IAC 1-1-3.1.

~~(d) If a medical expense that is subject to payment by a third party is submitted to the county department in a month later than the month in which the service is provided, no portion of the expense will be allowed in the spend-down eligibility determination until the third party has adjudicated and paid its obligated amount. The portion of the expense that is paid by the third party shall not be allowed in the spend-down eligibility determination. The portion of the expense for which the recipient remains liable after the third party has paid its obligated amount shall be allowed toward spend-down eligibility.~~

~~(e) An expense that is subject to payment by a third party shall be allowed in the spend-down eligibility determination if it is submitted to the county department in the month in which the service is provided, with the following limitations:~~

~~(1) Expenses for Medicare covered services are not allowed for recipients who are eligible as qualified Medicare beneficiaries under 42 U.S.C.1396a(a)(10)(E)(i).~~
~~(2) The allowed amount of an incurred expense for which the provider of service accepts Medicare assignment shall not exceed the Medicare approved amount. However, if the Medicare approved amount is not verifiable, the provider's usual and customary charge for the service will be allowed.~~
~~(3) If a liable third party has paid a portion of the expense at the time the expense is submitted, the portion of the expense that has been paid by the third party shall not be allowed in the spend-down eligibility determination.~~

~~(f) If the applicant's anticipated medical expenses do not exceed his or her excess income, his or her application will be denied. Such an applicant may reapply at any time.~~

(d) Claims submitted by Medicaid participating providers for services rendered to enrolled Medicaid recipients will credit the recipient's spend-down obligation in the month of the service and in the order of submission. A service that is not payable by the Medicaid program under 405 IAC 5 will not credit the spend-down obligation, except for a service that is not covered for the following reasons:

(1) The service is subject to a benefit limit; and
(2) There is no provision for obtaining prior authorization for coverage for services that exceed the benefit limit.

Any amount paid or payable by a third party will not credit the spend-down obligation. The amount owed by the recipient after the third party has adjudicated the claim will credit the spend-down.

(e) Incurred medical expenses for services for which claims cannot be submitted directly by Medicaid providers must be submitted to the county office for the purpose of crediting the spend-down obligation. The documentation of an expense submitted to the county office must be a bill, a receipt, or other documentation of the individual's liability for the expense. The following are examples of expenses that must be submitted to the county office:
(1) Expenses incurred before the individual was eligible for Medicaid.
(2) Expenses incurred by the recipient's spouse or other person whose income is considered in determining the recipient's eligibility.
(3) Expenses incurred for services provided by a non-Medicaid provider.

(f) For expenses submitted to the county office under subsection (e), the spend-down obligation will be credited for the month following the month of submission to the county office or, at the request of the recipient, in the month of service or in the month of submission of the expense to the county office. The incurred medical expense shall credit spend-down in subsequent months until the entire balance of the expense has been applied. The following incurred medical expenses will be credited toward spend-down under this subsection:
(1) Medical care provided by physicians, psychiatrists, and other licensed medical practitioners.
(2) Laboratory testing, x-rays, and other diagnostic procedures.
(3) Dental services provided by a licensed dentist, including dentures.
(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 to prescribe legend drugs under Indiana law.
(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, except those items identified as noncovered medical supplies under 405 IAC 5.
(10) Durable medical equipment if ordered in writing by a licensed physician except those items listed as noncovered equipment under 405 IAC 5-19-18.
(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 a friend or family member drives the individual to medical services, mileage cost is allowed at the rate per mile established by the Indiana legislature for state employees.
(17) The premium of the recipient's spouse who receives Medicaid for Employees with Disabilities (MED Works).
(18) Medicaid copayments and any copayments required by other health coverage programs or health insurance carriers.
(19) Premiums for health and hospitalization insurance policies that limit benefits to the reimbursement of medical expenses.
(20) Medicare premiums.

~~(g) If a recipient does not submit medical expenses to the county department to meet his or her spend-down for four (4) consecutive months, medical assistance shall be discontinued.~~ *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-10; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1021, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Jul 25, 1995, 5:00 p.m.: 18 IR 3382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Sep 7, 2004, 5:00 p.m.: 28 IR 178; filed Jul 18, 2005, 1:00 p.m.: 28 IR 3579) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-12) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-10) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

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