FAA5.O Medical Expense Deduction (MD)

01 MD - Purpose

The purpose of this chapter is to provide policy and procedures to complete an eligibility determination in the Medical Expense Deduction (MD) MA category.

The following Indicator Codes display in the CAT field on MADA when eligibility has been determined in the MD category:

- MD
- PD (pregnant participant)

(See Medical Expense Deduction Overview)

02 Medical Expense Deduction - Overview

Any application for MA may result in a Medical Expense Deduction (MD) determination.

Participants are potentially eligible for the MD category only when both of the following apply:

- The budgetary unit is financially responsible for medical expenses incurred in one of the following:
  - The month of application
  - The month prior to the month of application
- A participant is income ineligible in ALL other MA categories. (See MA Category Cascading)

WARNING

Some MD participants may be eligible in an MA category other than MD. Do not delay an eligibility determination for these participants while determining eligibility for an MD participant.

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Policy and procedures regarding the Medical Expense Deduction MA category are outlined as follows:

- MD - Application Process
- MD - Family Budgetary Unit
- MD - Eligibility Factors
- MD - Determination Process
- MD - Notices

03 MD Application Process - Overview

When the PI states ANY participant has incurred medical expenses in the MD expense period, key Y in the MED EXP field on MAGH for each participant who has incurred medical expenses. This allows AZTECS to complete an MD determination for the entire MD family budgetary unit.

Request verification of the medical expenses, income and resources.

Complete an MA determination. When the RESULT field on MADA displays PASS, authorize MA and send the appropriate MA approval notice.

When the RESULT field on MADA displays PEND, complete the following:

- Request medical expenses, including the date and source, for the application month and the month prior to the month of application.
- Request verification of resources, when applicable.
- Complete all fields on the MA (MED) Spend down Worksheet (FAA-1146A). Make entries daily to determine the allowable medical expenses to key on SPME.
- Accesses the MD screens through MADA, by keying S in the SEL field next to an MD Family Budgetary Unit participant.
- Key SPMI and SPDC

WARNING

When calculating the MD income maximum, multiply the MD income standard amount (see MD Standard Table) by three, then round up to the nearest whole dollar amount. Subtract this amount from the MD family budgetary unit's TOTAL countable income amount during the MD income period to determine the amount needed to meet spend down. (See Example Budgeting MD Income)

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- Key SPME daily when possible.
- Complete the eligibility determination. When MADA displays PASS in the RESULT field, complete the following (See MD Date of Eligibility):

  Set an alert on EWAL for the MD Informal Renewal

  Place a screen print of SPMS in the case file(g)

  Authorize MD

  Send the PI one of the following notices:

  - M121 notice when a representative applied for a participant who is deceased.
  - M122 notice when a participant applied.
- When the participant's allowable expenses are not enough to reduce income to the MD Income Standard complete the following:

  Place a screen print of SPMS in the case file on top of the application.

  Deny the application using the IM Denial or Closure Reason Code.

  Send the M208 notice to the PI.

  NOTE The application can be denied at any time when BOTH of the following occur:

  - ALL information has been received.
  - The applicant is NOT potentially eligible.

(See Application Requirements for additional policy)

04 MD Family Budgetary Unit - Overview

When determining eligibility in the MD category, the following examples of participants, when living together, must be included in the MD family budgetary unit:

- A parent and that parent's minor children.
- A married couple without children.
- A married couple and the minor children of either or both spouses.
- Unmarried parents and their minor children, when the unmarried parents have a child in common. (See Example Family Budgetary Unit)

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- The parents and children of a minor parent.
- A participant without children.

When a participant is pregnant, the MD family budgetary unit is increased by the number of unborn children.

NOTE SSI recipients are NOT included in the MD family budgetary unit.

WARNING

A participant may die or leave the budgetary unit in the application month or following months. When this occurs, complete an MA determination for that participant ONLY in the months in which they were actually present in the budgetary unit.

(See Changes in PI when the PI leaves the budgetary unit)

05 MD Eligibility Factors

Eligibility factors for MA are listed in the Eligibility Factors Table.

The following additional eligibility factors are used in the MD category:

- MD - Resources
- MD - Income
- MD - Medical Expenses
- MD - Third Party Liability (TPL)

A MD Resources

Policy and procedures regarding resource determination for the MA MD category are outlined as follows:

- MD Ownership and Availability
- MD Resource Verification
- MD Reduction of Resources

To be potentially eligible for the MA MD category, the resources of the MD family budgetary unit must be within the MA Resource Limit.

Resources are not countable in any other MA category.

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AZTECS counts resources of the following participants to the MD family budgetary unit:

- All participants included in the MD family budgetary unit, even when that participant does not request MA.
- Nonparent Specified Relatives (NPSR) who request MA.

EXCEPTION

Resources of the following participants are NOT COUNTABLE to the MD family budgetary unit:

- Non-relatives
- SSI recipients

.01 MD Ownership and Availability

Resources counted for the MD family budgetary unit are based on ownership and availability. Determine ownership and availability of resources based on the following:

- Jointly owned resources are indicated as follows:

  Ownership records with the words AND or AND/OR between the owners' names are available to each owner unless one of the owners refuses to sell. When all owners are participants in the MD family budgetary unit, a consent to sell is not required.

  Ownership records with the word OR between the owners' names are available to each owner.

- Unavailable resources can be any of the following:

  Irrevocable trust funds.

  Funds in accounts established by SSA, Veteran's Administration, or similar sources that are mandated to be used for the benefit of a person not residing with the MD family budgetary unit.

  Resources being disputed in divorce proceedings or in probate matters.

  Real property located on a Native American reservation.

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.02 MD Resource Verification

Verify the value of all countable resources using the verification process.

NOTE Use the participant's verbal or written statement to verify cash on hand.

Policy and procedures to verify resources are outlined as follows:

- Required Verification – Financial Accounts
- Required Verification – Liquid Assets
- Required Verification – Vehicles
- Required Verification – Other Assets

When verification of resources cannot be obtained through the verification process and the participant fails to provide, deny MA on MADA. (See Resource Verification)

.03 MD Reduction of Resources

An MD family budgetary unit whose income does not exceed the income limit, but whose resources are over the limit, may reduce resources to meet the resource limit. Resources MUST be below the limit on the day the MD determination is made. (See MD Resource Limit)

When resources were over the MD resource limit, and they have been reduced, determine the effective date of eligibility as follows:

- When resource eligibility is met in the same month income spend down is met, the effective date of eligibility is the date income spend down is met. (See Examples Resource Reduction 1 and Resource Reduction 2)
- When resource eligibility is met in the month prior to the month income spend down is met, the effective date of eligibility is the date income spend down is met. (See Example Resource Reduction 3)
- When resource eligibility met in the month following the income spend down is met, the effective date of eligibility is the first day of the month the resource eligibility is met. (See Example Resource Reduction 4)

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(See MD Date of Eligibility)

When resources continue to exceed the limit on the last day of the MD Expense Period, deny the application.

B MD Income Overview

Policy and procedures regarding income and budgeting for the MD category are outlined as follows:

- MD Income Period
- MD Budgeting Income
- MD Income Deductions

.01 MD Income Period

In the MD category, the income of each participant in the MD family budgetary unit must be considered.

NOTE The MD budgetary unit's adjusted net income cannot exceed 40% of the current FPL for the MD budgetary unit size. (See MD Standard Table)

The MD family budgetary unit's countable income over a three month period is used in the MD determination. The three month income period consists of the following:

- The month of application
- The month following the month of application
- The second month following the month of application

(See Example Income Period)

.02 MD Budgeting Income

The income budgeted must consist of the three month MD income period.

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Key the income for the month of application on the following income screens as appropriate:

- UNIE
- UNIN
- EAIN
- SEEI

Key the income on SPMI for both of the following:

- The month following the month of application.
- The second month following the month of application.

(See Projecting Income for additional policy)

.03 MD Income Deductions

Each employed MD participant is allowed the following earned income deductions:

- Cost of Employment
- MA Dependent Care

C MD Medical Expenses

Policy and procedures regarding medical expenses for the MA MD category are outlined as follows:

- MD Expense Period
- MD Allowable Expenses
- MD Nonallowable Expenses
- MD Expense Verification

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.01 MD Expense Period

An MA application has only ONE MD expense period. The MD expense period consists of the following time frames:

- The month prior to the application month
- The application month
- The month after the application month

Medical expenses incurred during the MD expense period may be used in the eligibility determination. (See Example Expense Period)

EXCEPTION

The cost of a prepaid contract agreement may be deducted as an allowable MD expense in the month the service is provided.

.02 MD Allowable Expenses

REVISION 03
(01/01/08 – 03/31/08)

The MD family budgetary unit may use MD allowable expenses (paid or unpaid) to reduce the MD budgetary unit's income when determining eligibility. (Also see MD Nonallowable Expenses)

Expenses may be incurred by participants who were in the budgetary unit during part of the MD expense period. When this occurs, the incurred medical expenses may be used to determine eligibility for the remaining participants when BOTH of the following apply:

- The participant who died or left the MD budgetary unit was an MD participant during the month the medical expenses were incurred.
- A participant who remains in the MD family budgetary unit is financially responsible for the incurred medical expenses.

EXCEPTION

When a child with incurred medical expenses moves from one of their parent's home into the other parent's home, the incurred medical expenses of the child go with the child. The MD family budgetary unit in which the child is currently residing can use the child's expenses for eligibility purposes.

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(See Examples MD Expense 1, MD Expense 2, MD Expense 3 and MD Expense 4)

Allowable medical expenses must be the financial responsibility of the MD family budgetary unit. It IS required that the medical expense be incurred in the United States. (Also see MD Nonallowable Expenses)

Allowable medical expenses include, but are not limited to, the following:

- Activity for Daily Living Services (ADLS)
- Artificial limbs or braces
- Assistive devices and durable medical equipment, and associated maintenance and repair costs
- Audiology services
- Blood and blood derivatives
- Chiropractic services
- Dental services
- Eyeglasses, artificial eyes, and eye appliances
- Family planning services
- Health insurance premiums, co-payments, and deductibles
- Hearing aids
- Hemodialysis services
- Homeopathic, naturopathic services
- Hospital inpatient services for acute care
- Inpatient mental disability services
- Inpatient psychiatric services
- Laboratory, X-ray services
- Licensed Behavioral Health Services
- Licensed Long Term Care facility services

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- Medical supplies
- Medicare premiums, copayments, and deductibles

EXCEPTION

Medicare Part B premiums paid by the State of Arizona are considered a vendor payment, and are not allowable. (See BDXI)

- MD Medical transportation costs incurred in the U.S.
- Nutritional supplements prescribed by a physician
- Occupational therapy services
- Optometry services
- Physical therapy services
- Physician services - office, home, clinic, inpatient
- Podiatry services
- Prescription drugs
- Psychiatric services - psychiatrist, psychologist
- Radiation therapy services
- Services provided in developmental disability facilities recognized by DES
- Speech therapy services
- The cost of purchasing and maintaining animals trained to assist disabled participants
- Allowable expenses paid by someone not in the MD family budgetary unit, which must be repaid

NOTE When a medical expense is not listed in this section or in MD Nonallowable Expenses, or is questionable, contact the FAA Policy Support Team (PST) via e-mail for clarification.

(See MD Expense Verification)

WARNING

When a participant is enrolled in Indian Health Services (IHS), see MD-IHS.

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.03 MD Allowable Expense Type – Activity for Daily Living Services

Activity for Daily Living Services (ADLS) are personal care services prescribed by a physician to individuals who are physically unable to perform activities for daily living.

Allowable ADLS expenses are limited to the following:

- Personal hygiene (bathing)
- Meal preparation
- Dressing
- Ambulatory assistance

The attendant providing the services does not need to be licensed. ADLS expenses are not allowable when either of the following occur:

- The services are provided by the spouse of the MD participant.
- The services are provided by the parent of a minor child who is the MD participant.

To allow ADLS expenses for the MD category, both of the following must be provided:

- The physician's statement verifying that the services are needed.
- The attendant's statement validating the service. The statement must have all of the following:

  Attendant's name, address, and phone number

  The date the services were provided

  The amount of the expense incurred

  The name of the person who received the services

.04 MD Allowable Expense Type – Licensed Behavioral Health

The expenses incurred by a participant living in a Licensed Behavioral Health Services (LBHS) facility are allowable in the MD category.

To verify the licensure of a LBHS, contact the Division of Behavioral Health Services License Unit. (See BHS License Unit)

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.05 MD Allowable Expense Type – Long Term Care

The expense incurred by a participant residing in a licensed long term care facility is allowable in the MD category.

Long term care facilities include the following:

- Licensed skilled nursing facility
- Licensed intermediate care facility
- Certified adult foster care facility

NOTE Structured room and board facilities are not considered medical long term care facilities.

To verify the type and licensure of a long term care facility, contact the Bureau of Health Care Institution Licensure. (See Health Care Institute License)

EXCEPTION

The following expenses incurred while in a long term care facility are not allowable expenses:

- Personal allowances
- The county subsidized portion of the expense

.06 MD Allowable Expense Type – Medical Transportation

Transportation costs incurred for travel in the United States to obtain emergency medical treatment at a medical facility are allowable for MD.

Non-emergency treatment must be prescribed by a licensed physician.

Allowable medical transportation costs may be incurred through the use of any of the following:

- Aircraft
- Ambulance
- Boat
- Bus

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- Taxi
- Train
- Private vehicle

Any one of the following transportation costs may be allowed:

- The Mileage Standard when private vehicles are used.
- The actual cost of fare when public transportation or common carrier is used.
- Private vehicle expenses may be claimed when the participant can provide verification of the actual expenses.

.07 MD Nonallowable Expenses

The following expenses are not allowed when determining eligibility in the MD category:

- Covered expenses incurred during the time the participant is in active MA status (See Example MD Nonallowable Expense)
- Custodial, room and board services
- Expenses incurred outside of the United States
- Expenses paid by any third party insurance (See MD-IHS)
- Expenses paid by someone not in the MD family budgetary unit as a vendor payment
- Expenses written off by the medical provider
- Over-the-counter medication, unless prescribed by a physician
- Transportation costs to a medical provider for routine, non-emergency treatment
- Vitamins and food supplements, unless prescribed by a physician

(See MD Allowable Expenses for expenses that can be used when determining eligibility in the MD category.)

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.08 MD Expense Verification

A medical expense must be verified to be allowed for the eligibility determination in the MD category.

Actual expenses must be used when available.

Reasonably anticipated charges incurred but not billed may be used when all of the following occur:

- Actual expenses are not available
- The participant meets all other eligibility factors
- It has been established that the medical procedure has occurred

WARNING

When a participant has third party liability, see MD TPL Verification for policy and procedures in determining allowable expenses in the MD category.

A participant statement is NOT acceptable verification of a medical expense. Verification may be obtained by either Documented Verification or Collateral Contact.

Medical expense verification must include the following:

- The type of medical expense.
- The date the expense was incurred.
- The amount of the expense the MD family budgetary unit is responsible to pay. (See MD Third Party Liability)
- The name of the person who incurred the expense.

NOTE A provider's statement of multiple medical services may be used as verification of medical expenses.

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D MD Third Party Liability (TPL)

Third Party Liability (TPL) is the obligation of a legally responsible person or company to provide medical support, health, or accident insurance for participants.

Policy and procedures regarding Third Party Liability (TPL) for the MD category are outlined as follows:

- MD TPL Allowable Deductions
- MD TPL Verification
- AHCCCS Medical Cost Recovery
- MD - IHS
- MD Worker's Compensation

.01 MD Third Party Liability Allowable Deductions

TPL includes, but is not limited to, medical support payments and insurance (health or accident) coverage.

Costs incurred by an MD participant that are covered by Third Party Liability (TPL) are not allowed as expense deductions when determining eligibility in the MD category.

Insurance programs provide payments for incurred medical expenses. When only a portion of the incurred expense is paid by the insurance program, the portion of the expense the participant is responsible to pay IS an allowable expense deduction for the MD category.

Types of insurance programs include, but are not limited to, the following:

- Private Health Insurance
- Health Maintenance Organization (HMO)
- Prepaid contract agreement
- Indian Health Services (MD-IHS)

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- Medicare Part A
- Medicare Part B
- Medicare Supplemental Insurance

(See MD TPL Verification for verification procedures)

.02 MD TPL Indian Health Services (IHS)

REVISION 15
(01/01/11 - 03/31/11)

Participants enrolled in Indian Health Services (IHS) may have some or all of their medical expenses paid by IHS. IHS eligible participants include, but are not limited to, the following:

- Native American tribal members
- Active and retired U.S. Public Health Service employees
- Dependents of U.S. Public Health Service employees

NOTE It is not required that U.S. Public Health Services employees and their dependents be Native Americans.

IHS eligible participants being treated at an IHS facility are not billed for their medical services.

A non-IHS medical provider may provide services at an IHS facility. When this occurs, the IHS patient may sign a contract or may agree to pay the provider separately for the services received.

Patients are referred to a non-IHS facility when IHS is not able to provide or does not have the facilities to provide the medical services needed.

The IHS Contract Health Unit determines whether IHS or the patient is responsible for payment of the services provided by a non-IHS facility. Contract Health may pre-approve and provide a purchase order to pay for the services provided.

Expenses for medical services that are not covered by IHS and are the financial responsibility of the patient are allowable medical expenses when determining eligibility in the MD category.

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A determination in the MD category may be needed for an eligible IHS participant. When this occurs, the Policy Support Team (PST) assists in obtaining information regarding MD allowable expenses. Elevate the facts of the case to the PST using the Indian Health Services Eligibility Request E-form. Complete all fields on the E-form.

The PST responds to the inquiry within five work days and advises the local office of which expenses are allowable in the MD determination. Place a copy of the E-form from the PST in the case file(g).

.03 MD TPL Worker's Compensation

REVISION 13
(07/01/10 – 09/30/10)

MA participants injured performing work related activities may file a Worker's Compensation claim with the Industrial Commission. When this occurs, the eligibility determination must not be delayed pending the outcome of the Worker's Compensation claim.

NOTE When a claim has been filed with Worker's Compensation, complete the Injury/Malpractice Referral (FAA-1147A) form.

When the MA participant with a Worker's Compensation claim is eligible for any category BUT MD, approve the application and send the appropriate notice.

The status of the Worker's Compensation claim must be verified on the day the MD determination is made.

When the MA participant is income ineligible for all MA categories, and due to incurred medical expenses PEND for the MD category on MADA, the following apply:

- The Worker's Compensation claim may be DENIED prior to the MD eligibility determination. When this occurs, use ALL incurred medical expenses the MD family budgetary unit is financially responsible to pay.
- The Worker's Compensation claim may be APPROVED prior to the MD eligibility determination. When this occurs, do not use any of the incurred medical expenses covered by the Worker's Compensation claim.

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- The Worker's Compensation claim may be pending at the time of the MD eligibility determination. When this occurs, complete the following:

  Use the incurred medical expenses in the MD eligibility determination.

  Set an alert on EWAL for the MD Informal Renewal.

  Send the appropriate MD approval notice.

  Send the FAA-1147A to Research and Analysis.

  Document CADO to support the MD eligibility determination.

When the claim is APPROVED AFTER the MD eligibility determination, do not complete a One Time Adjustment to the effective date of eligibility.

When the claim is DENIED AFTER the MD eligibility determination, complete a One Time Adjustment to the effective date of eligibility.

.04 MD TPL Verification

Contact the Third Party Liability (TPL) source to establish an allowable expense.

When the participant has TPL, contact the responsible TPL source to request the amount of the medical expense that the TPL source will pay.

WARNING

Complete the Injury/Malpractice Referral (FAA-1147A) form when an MA participant has been injured, or involved in any of the following:

- Accident
- Medical malpractice

When the TPL source cannot verify the actual amount incurred expenses the TPL source will pay, complete the following:

- Obtain the rate of coverage the TPL source pays
- Contact the medical providers involved and obtain the total expenses the participant and the TPL source are responsible to pay

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- Apply the rate of coverage to the incurred expenses
- The difference is the amount that can be used as a deduction in the MD category

(See Example TPL Expense)

When the medical services have been provided at either of the following, only the amount the participant is responsible to pay can be used:

- At a reduced rate
- Written off a portion of the bill as uncollectible

NOTE Verify the amount written off as uncollectible with the medical provider.

When the participant has been involved in an accident and has casualty insurance but no settlement has been made, complete the FAA-1147A.

To allow medical expenses incurred as a result of an accident, determine whether a settlement or payment has been made. Resolved with the participant whether any of the following apply:

- The injured party has homeowner's, automobile, or any other type of insurance
- The injured party has Worker's Compensation
- A settlement has been made with the insurance company
- When applicable, the terms of the settlement
- Any payments have been received
- Any medical expenses have been paid by the insurance company or by any other party
- Other parties were involved in the accident
- The other party has insurance
- The injured party has received a settlement or payment from the insurance company

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(See AHCCCS Medical Cost Recovery for additional policy and procedures)

Once expenses have been paid by any TPL source the expense may no longer be used for spend down.

06 MD Determination Process

Policy and procedures regarding the MD determination process are outlined as follows:

- MD Time Frames
- MD Keying Procedures
- MD Date of Eligibility
- Adjustment of Effective Date
- MD Approval Periods
- MD Informal Renewal
- MD Changes

A MD Time Frames

The following time frames apply to the MD category:

- Hospitalized participants must have an eligibility determination completed within seven calendar days from the date of application when no additional information or verification is needed.

  NOTE When MD eligibility cannot be determined within seven calendar days, key the appropriate Untimely Reason Code in the UNTIMELY GOOD CAUSE field on MADA.

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- Non-hospitalized participants must have a determination completed within 45 calendar days from the application date.

  NOTE When MD eligibility cannot be determined within 45 days, key SP (SPend down not met) in the UNTIMELY GOOD CAUSE field on MADA.

WARNING

When it has been verified that an MA participant has not met the 40% FPL limit by the end of the month after the month of application, deny the application. The participant may reapply at any time. When this occurs, new income and expense periods are established.

Only the MD specialist can deny applications that display PEND in the MD (PD for pregnant participants) category on MADA.

B MD Keying Procedures

Keying procedures in the MD category are outlined as follows:

- MD MADA
- SPMI
- SPDC
- SPME
- SPMS

.01 MD Keying MADA

When Y is keyed in the MED EXP field on MAGH for any participant with medical expenses, one of the following occurs:

- When the participant is eligible in an MA category other than MD, the following display:

  The appropriate MA category in the CAT field

  PASS in the RESULT field

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- When the participant fails income eligibility, the following display:

  MD in the CAT field

  PEND in the RESULT field

  To complete an MD eligibility determination, key S in the SEL field next to the participant who has incurred medical expenses. (See SPMS)

When N displays in the MED EXP field on MAGH for all participants, one of the following displays on MADA:

- When the participant is eligible for MA, the appropriate MA category displays in the CAT field and PASS displays in the RESULT field
- When the participant is ineligible in any MA category, the MA category displays in the CAT field and FAIL displays in the RESULT field

Authorize the determination on MADA.

Send appropriate notices.

C MD Date of Eligibility

The effective date of eligibility for the MD category cannot begin earlier than one of the following:

- The first day of the month of application
- The date the income is reduced to the MD Income Standard

Determine the effective date of eligibility as follows:

- When either of the following occur, the effective date of eligibility is the first day of the month of application:

  The income is reduced to the MD income standard prior to the month of application. (See Example MD Eligibility Date 1)

  The total income for the MD Income Period is less than the three month income standard. (See Example MD Eligibility Date 4)

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- When either of the following occur, the effective date of eligibility is the date income is reduced to meet the MD income standard:

  The income is reduced to the MD income standard in month of application. (See Example MD Eligibility Date 2)

  The income is reduced to the MD income standard in the month following the month of application. (See Example MD Eligibility Date 3)

- When the income is reduced to the MD income standard and resource eligibility is a factor, see MD Resource Reduction for the effective date of eligibility.

When the MD date of eligibility is the first day of the month following the month of application due to resource eligibility, complete the following:

- When the AZTECS case consists of more than one person, complete the following:

  Key OU in the PT field on SEPA for the MD participant.

  Authorize all eligible participants.

  Copy details into the next month.

  Key IN in the PT field on SEPA for the MD participant.

  Key the first day of the month following the month of application in the START DAY field on SEPA.

- When the AZTECS case consists of one participant, key the first day of the month following the month of application in the BEN PRORATE DATE field on APMA.

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D MD Adjustment of Effective Date

The effective date of eligibility may be adjusted ONE TIME to an earlier date. The purpose of adjusting the effective date of eligibility for approved MD cases is to allow the MD family budgetary unit the earliest possible date of eligibility.

EXCEPTION

Approved MD cases do not have a one time adjustment when the effective date of eligibility is one of the following:

- The first day of the application month
- The first day of the month after the application month due to MD resource reduction
- The date of application, and the participant is not responsible to pay for medical expenses prior to the date of application

FAA staff must obtain the necessary information to complete the one time adjustment. (See Allowable MD Expenses)

Policy and procedures regarding adjusting the effective date are outlined as follows:

- Time Frame for MD Adjustment
- Review of MD Cases
- MD Re-evaluation Process
- No Adjustment Allowed Process
- Adjustment Allowed Process

WARNING

Policy and procedures regarding the one time adjustment are the same for both OPEN and CLOSED cases.

.01 Time Frame for MD Adjustment

A one time adjustment of the effective date of eligibility must be completed within 60 calendar days from the date of approval.

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AZTECS completes the following 30 calendar days from the completion of an MD approval:

- Sets an ACTS Alert. (See MD ADJUSTMENT REQUIRED for actions to take on the alert)
- Sends the PI the X046 notice.

The one time adjustment can be completed at any time prior to the 60th calendar day from the date of approval when both of the following occur:

- All verification of medical expenses prior to the spend down date has been received.
- The PI states there are no earlier medical expenses.

AZTECS generates the MD One Time Adjustment Daily Report (MR610). The designated supervisor must assign the alerts and monitor the timely completion of the one time adjustments. (See SAR- MR Reports)

.02 Review of MD Cases

Upon receipt of the assigned ACTS alert, the EI is responsible for completing the MD one time adjustment. The EI must complete the following:

- Review the following to obtain the original amount of spend down and effective date of eligibility:
  The case file(g).
  The CADO documentation.
  The spend down screens, and forms.
- Review all medical expenses used to determine the original date of eligibility.
- Review the case file for additional bills that were not used to determine eligibility.

NOTE The original determination may have been completed primarily using hospital expenses. These expenses frequently do no include costs incurred from physicians, laboratories, pharmacies, or transportation.

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When information in the case indicates a participant received medical treatment, complete the following:

- Contact the facility (Billing Department) for a printout of the final itemized bill.

  NOTE FAA staff located in medical facilities may assist the local office in obtaining this information.

- Contact other sources of medical expenses. This includes, but is not limited to, the following:

  Emergency transportation.

  Emergency room and other physician charges.

  Prescriptions.

- Contact the participant to obtain other sources of medical expenses.
- Contact the participant's other medical providers to obtain required information.

Document CADO regarding when, who, and how contact was made.

.03 MD Re-evaluation Process

Complete the re-evaluation process for adjusting the effective date of eligibility manually using a new MA (MED) Spenddown Worksheet (FAA-1146A).

WARNING

Do not key AZTECS when completing the adjustment of the effective date.

Complete all fields on the FAA-1146A as follows:

- Log the allowable expenses for the entire MD family budgetary unit as follows:

  Use ALL available expenses.

  Begin with the earliest date of service in the MD Expense Period and work forward.

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Ensure that all MD Allowable Expenses incurred prior to the date of application are logged first, in date of service order.

- Subtract the allowable expenses from the earliest date of service from the spend down amount and work forward. Document the balance in the BALANCE column on the FAA-1146A.

The date the BALANCE column reaches zero (or less than zero) is the effective date of the one time adjustment and the new effective date of eligibility.

When the BALANCE reaches zero on the same date as the date spend down is displayed in AZTECS, no one time adjustment is allowed. (See No Adjustment Allowed Process)

When the BALANCE reaches zero on an earlier date than the original effective date of eligibility displayed in AZTECS, a one time adjustment is allowed. (See Adjustment Allowed Process)

Document in the COMMENTS/CALCULATIONS section of the FAA-1146A that the review of the original determination was completed.

.04 No Adjustment Allowed Process

When the re-evaluation of the MD case indicates that no adjustment of the effective date of eligibility is allowed, complete the following:

- Document CADO and the Case Record History (FA-015) form with the actions taken.

  NOTE The FA-015 may be documented to see CADO.

- Place the MA (MED) Spenddown Worksheet (FAA-1146A) with supporting documentation in the case file(g) on top of the current application.
- Send the M521 notice to the PI.

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In addition, when the MA application originated at a hospital, complete the following:

- Review the case file for a signed Authorization to Share Information form. This may be either an FAA-1145A or the signed section of the official AHCCCS application.
- When either of the forms are completed, signed, and in the case file, screen print the M521.
- Using local office procedures, route the screen print of the M521 to the appropriate entity, as identified on the FAA-1145A or the AHCCCS application. On the envelope write ATTENTION: Patient Financial Services.
- When neither of the forms is completed, signed, and in the case file, send the M521 to the PI only.

.05 Adjustment Allowed Process

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(07/01/11 – 09/30/11)

The re-evaluation of the MD case may indicate adjustment to the original date of eligibility is allowed. When this occurs, the EI must complete a manual process to provide the information to AHCCCS. Complete the following:

- Elevate the facts of the case to the R&A Unit using the MD One-Time Adjustment Request E-Form.
- Document CADO with the adjusted begin date and the reason for the adjustment.
- Place the MA (MED) Spenddown Worksheet (FAA-1146A) with supporting documentation in the case file(g).
- Place a copy of the e-mail in the case file on top of the FAA-1146A.

R&A completes the following:

- Notifies AHCCCS within two work days of the new effective date of eligibility.
- AHCCCS notifies R&A within two work days when the new effective date of eligibility is posted in PMMIS.

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- Notifies the local office MD specialist via e-mail that the new date of eligibility is posted in PMMIS by AHCCCS.
- Sets an EWAL alert to advise the MD specialist to send the M520 notice to the PI.

When R&A notifies the local office of the posting by AHCCCS, the local office must complete the following:

- Send the M520 notifying the PI of the new date of eligibility, within two work days of the date of receipt from R&A.
- When the MA application originated at a hospital, complete the following:

  Review the case file for a signed Authorization to Share Information form. This may be either an FAA-1145A or the signed section of the official AHCCCS application.

  When either of the forms are completed, signed, and in the case file, screen print the M520.

  Using local office procedures, route the screen print of the M520 to the appropriate entity, as identified on the FAA-1145A or the AHCCCS application. On the envelope write ATTENTION: Patient Financial Services.

  When neither of the forms is completed, signed, and in the case file, mail the M520 to the PI only.
- Document CADO and the FA-015 with the date AHCCCS posted the new effective date of eligibility and ALL actions taken.

  NOTE The FA-015 may be documented to see CADO.

- Place the verification received from R&A in the case file on top of the FAA-1146A.

E MD Approval Periods

AZTECS assigns a six month approval period when an MD participant is determined eligible. The first three months of eligibility is a protected eligibility period. (See Protected Eligible Period)

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When changes are anticipated, complete an MD informal renewal to determine continued eligibility for the next three months of the approval period.

When no changes are anticipated, no MD informal renewal is required.

F MD Informal Renewal

An MD informal renewal is only required when changes in any of the following are anticipated:

- Income
- Medical services
- A combination of income and medical services

Upon completion of the MA approval, set an alert on EWAL for the first day of the month, two months following the effective date of eligibility. (See Examples Informal Renewal 1, Informal Renewal 2, Informal Renewal 3 and Informal Renewal 4)

- Telephone the PI and review any changes in income, resources or the need for on-going medical services.
- Effect any changes that have occurred for the first month after the Protected Eligible Period. (See Changes After Approval of MD)

When the PI has no phone or does not respond to the phone call, complete the following:

- Send the C011 notice requesting the PI contact the local office for an informal renewal.
- When the PI responds, review any changes in income, resources, or the need for on-going medical services that have occurred.
- Effect any changes for the first month after the protected eligibility period.

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- When the PI fails to respond to the C011, stop MD eligibility, for the first month possible, allowing for NOAA.

WARNING

Every MA application has only ONE MD Expense Period. AZTECS does not allow an MD determination after the MD Expense Period without registering a new application.

G MD Changes

Changes may be reported that have an effect on the eligibility of the MD participant. The following policy applies to the MD category:

- Changes with MD Application Pending
- Changes After Approval of MD

.01 MD Application Pending

When a change is reported while the MD application is pending, the following apply:

- Redetermine eligibility in other MA categories.
- Approve the participant in the other MA category when eligible.
- For the effective date of approval, see the START DAY field on SEPA.

WARNING

When adding or removing a participant in a pending MD application, see Adding or Removing an MD Participant.

When the participant is NOT eligible in another MA category, continue with the MD determination.

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.02 Adding or Removing an MD Participant

When adding or removing a participant in a pending MD application results in eligibility in another MA category, the following apply:

- Approve the participant in the other MA category.
- The effective date of approval is the first day of the month the change occurred.

When participants are ineligible in any category other than MD and an MA application is pending, complete the following:

- Determine eligibility for MD.
- Add or remove the income, resources, and medical expenses of the participant moving in or out of the home the month the move occurred.
- Redetermine the countable income and the new 40% of the current Federal Poverty Level.
- Redetermine the new amount of medical expenses allowed for eligibility in the MD category.
- Determine the effective date of approval for the MD category.

NOTE Adding or removing a participant may result in eligibility in the MD category at an earlier date than when the participant moved in or out of the home. (See Example Pending MD Application)

.03 After Approval of MD

REVISION 06
(10/01/08 - 12/31/08)

When changes are reported after an approval determination is made in the MD category, do not stop MD eligibility until after the three month protected eligibility period has elapsed.

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Effect a change for the fourth month of the approval period when the following apply:

- The change is discovered during the protected eligible period
- The change results in ineligibility

(See MD Informal Review)

EXCEPTION

During the first three months of MD eligibility, the MD case may be closed for the following reasons ONLY:

- Death
- Incarceration
- Move out of state
- Voluntary withdrawal

When a change results in continued eligibility for an MD participant, continue benefits for the remaining months of the six month approval period, as applicable.

When adding or removing a participant from an active MD case, during the protected eligible period, causes eligibility in another MA category, complete the following:

- Determine eligibility for the participant in the other category the month after the change was reported
- Send the M000 notice.

07 MD Screen Descriptions - Overview

To determine eligibility in the MD category, key S in the SEL field on MADA to access the SPENDDOWN MEDICAL SUMMARY (SPMS) screen.

On SPMS select any MD participant to key income and expense information to complete an MD determination. This includes MD participants determined eligible in other MA categories.

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Key the applicable code in the DET field for the participant and press ENTER to access the corresponding SPENDDOWN screen, as follows:

- I - SPMI (SPENDDOWN MEDICAL INCOME)
- D - SPDC (SPENDDOWN DEPENDENT CARE)
- M - SPME (SPENDDOWN MEDICAL EXPENSE)

When any of the SPENDDOWN screens are keyed, return to SPMS to display a summary of the information keyed.

WARNING

An MD determination cannot be completed without keying information on SPME.

SPMI does NOT automatically recalculate income when information is added, deleted, or changed on income screens (EAIN, UNIN, SEEI, STAI)

A SPMI (SPENDDOWN MEDICAL INCOME)

Access SPMI from SPMS. SPMI is used to determine the MD family budgetary unit's net income for the MD Income Period.

When SPMI is accessed, the participant's income for the initial month displays in the TOTAL INCOME field.

The information for the initial month is the information keyed on the following screens for the initial month:

- UNIE
- UNIN
- EAIN
- SEEI

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Determine the prospective income for each of the two months after the application month by anticipating income. Consider potential changes in income, such as the following:

- Changes due to time off of work.
- Any additional pay to be received, such as sick leave.
- Anticipated return to work as verified by the doctor or hospital.

Complete SPMI for the MD income period by keying the following:

- The appropriate income category in the INC CAT field.
- The income type in the INC TYPE field.
- The income sub type, when applicable, in the SUB TYPE field.
- The source of the income in the INCOME SOURCE NAME field.
- The month the income is anticipated to be received in the INCOME DATE field. The income date keyed must be within the MD income period or the following edit message displays:

  ERROR INCOME DATE OUTSIDE INCOME PERIOD

  NOTE AZTECS displays in the INCOME DATE field all three months of the MD income period for each participant with income, based on the date of application.

- The total monthly income in the TOTAL INCOME field.

  NOTE Key zeros when there is no anticipated income for a participant in any month of the MD income period in order to process SPMI.

- The anticipated hours worked in the HRS field.
- The method of verification in the VR field.
- The date information is due in the PEND field, when verification has been requested.

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Key an I in the OTHER ITEMS field on any of the other MD SPENDDOWN screens to access SPMI for the participant selected on SPMS.

WARNING

Once SPMI has been accessed through MADA, all changes keyed in the AZTECS income screens MUST also be keyed on this screen to change income for the three month income period.

B SPDC (SPENDDOWN DEPENDENT CARE)

Access SPDC from SPMS. SPDC is used to determine the allowable dependent care expenses for the MD Income Period.

When SPDC is accessed, the participant's dependent care expense for the initial month is displayed in the AMOUNT field.

Determine the projected dependent care expenses for each of the two months after the application month and key the amounts in the AMOUNT field.

Key a D in the OTHER ITEMS field on any of the other MD SPENDDOWN screens to access SPDC for the participant selected on SPMS.

C SPME (SPENDDOWN MEDICAL EXPENSE)

SPME is used to key ALL allowable medical expenses incurred for the selected participant during the MD Expense Period. To access SPME, key M in the DET field on SPMS next to the participant.

To complete SPME, key the following:

- The name of the medical provider who provides the allowable medical service in the PROVIDER field.

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- The date a medical expense was incurred in the DATE OF SERVICE field. The date keyed must be within the MD Expense Period.

  NOTE When an expense date that is not in the MD expense period is keyed, the following edit message displays:

  ERROR EXPENSE DATE OUTSIDE EXPENSE PERIOD

- The allowable expense in the ALLOWABLE AMOUNT field.

  NOTE Use the MA (MED) Spenddown Worksheet (FAA-1146A) to log the manual calculations for allowable medical expenses.
  When multiple providers provide services on the same day, use a separate entry for each provider.

- The method of verification in the VR field.
- The date information is due in the PEND field, when verification has been requested.

When 14 medical expenses have been keyed, key M in the OTHER ITEMS field on SPME to access an additional SPME Key additional medical expenses on this screen.

Complete this process for each participant who has allowable medical expenses within the MD Expense Period.

D SPMS (SPENDDOWN MEDICAL SUMMARY)

Key an S in the OTHER ITEMS field on any of the other MD workscreens or in the SEL field on MADA to access SPMS. SPMS displays the summary of all participants' information keyed on the following:

- SPMI
- SPDC
- SPME

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The NET INCOME field displays the total net income for the MD family budgetary unit. The net income of the entire MD family budgetary unit displays next to each MD family budgetary unit participant.

SPMS displays the results of the information keyed in AZTECS and on the SPENDDOWN SCREENS.

NOTE Use the MA (MED) Spenddown Worksheet (FAA-1146A) to log the manual calculations for allowable medical expenses.

When multiple providers provide services on the same day, use a separate entry for each provider.

WARNING

When income or expenses are keyed on EAIN, UNIN, SEEI, STAI, or EXNS after SPMS is processed, the SPENDDOWN screens must be accessed and rekeyed.

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