1.24 SPECIAL PROCEDURES IN THE MEDICAID APPLICATION PROCESS

A. SPOUSES APPLY - ONE APPROVED, ONE PENDING

When an application is made for a couple and one spouse is eligible, but the application for the other remains pending because disability has not been established, the procedure is as follows:

- Approve the application for the eligible spouse. Deeming procedures in Chapter 10 apply.

- Send an approval notice to the eligible individual and include an explanation that eligibility for the spouse has not been established and the reason.

If the spouse is determined eligible at a later date, the procedures depend upon whether or not the previously ineligible spouse has income, whether or not such income was deemed to the recipient and whether or not there is a spenddown.

When the income of the previously ineligible spouse equals $0, or has been deemed to the recipient spouse, or does not cause the AG to have a spenddown, the following procedures apply.

- Take data system action to add the spouse to the AG. The beginning POC or POE for the spouse is the same as for the recipient;

- Send an approval notice to the recipient to inform him that eligibility for the spouse has been established and the date on which his medical coverage begins.

- If the individual is added after the deadline date in the 6th month of the POC, proper RAPIDS procedures must be followed to insure issuance of a medical card.

When the previously ineligible spouse has income, but it was not deemed to the recipient spouse, and it causes the AG to have a spenddown, the following procedures apply.

If the eligible spouse did not previously have a spenddown, but the addition of the previously ineligible spouse and his income makes the AG subject to spenddown, the following actions are taken:

- The previously ineligible spouse is added to the AG; and

- The AG is closed after proper notice and is reopened with a new POC. The new POC must not cover any period of time in which the AG was in a POE.

- The AG must be supplied with proper notice about the spenddown and the procedures which now apply.

If the eligible spouse had a spenddown which was met and is currently in an active AG, the following actions are taken:

- Add the previously ineligible spouse to the AG for the current POC. The AG is not closed prior to the end of the current POC due to increased countable income.

- When the AG reapplies for a new POC, all income is counted and appropriate spenddown procedures apply.

If the spouse is determined ineligible, the Worker sends the recipient a denial notice.

Appropriate RAPIDS Screens must be updated and a recording made in RAPIDS case comments about the denial.

B. DEATH OF THE ONLY INDIVIDUAL PRIOR TO APPLICATION OR APPROVAL

Death of an individual does not interfere with approval of a Medicaid application. However, special procedures are required when the only member of a Medicaid AG dies prior to making an application. If an application is made prior to an individual's death, the application is processed as usual and approved, if eligible. This item outlines the special procedures that the Worker must follow in the application process and at approval.

1. Who Must Be Interviewed And Sign The Application

Another individual makes the application on behalf of the deceased person. It is preferable that the person be a relative, but any other individual who is interested may make the application on behalf of the deceased person.

The Worker must obtain as much information as possible about the deceased person's income and assets, but routine verification is not required.

2. MRT Referral

It is not necessary to refer the case to MRT when the deceased person's incapacity or disability resulted in his death. However, a MRT referral may be necessary to establish incapacity, blindness or disability when there is a request for Medicaid coverage for a month(s) prior to the person's death and such incapacity, blindness or disability was not the cause of death, or the Worker is unable to determine if the incapacity, blindness or disability existed during the month(s).

All other policies and procedures related to incapacity or disability coverage groups apply.

C. DOCUMENTATION AND REVIEW OF PENDING MEDICAID APPLICATIONS

To document the reason for any delay in processing a Medicaid application, the Worker must record in CMCC:

- All actions taken in processing the application.

- The results of required case reviews.

The instructions for these procedures are found below. A rebuttable presumption that the application was not acted on within a reasonable period of time exists when conditions such as, but not limited to, are met:

- Proper documentation, as shown below, which establishes that delay is due exclusively to factors beyond the control of the Department, is not in the case record;

- Documentation for the required case review is not in the case record.

This presumption may be rebutted only by clear and convincing evidence that all necessary actions by the Department for processing the application were undertaken in a timely fashion. This presumption may not be rebutted solely by the testimony of a Worker who failed to meet the documentation requirements.

1. Instructions For Documentation For Pending Medicaid Applications

   Action on each application must be noted in CMCC and by coding the appropriate RAPIDS Screens.

EXAMPLE:

Date	Recording	Worker	Data Transmission
10/10/95	Client applied. All elig. req. met except spdwn. ES-6 and 6A given for medical bills	Jones	N/A See case comments of 10/10/95
11/6/95	Medical bills received ($432). Not enough to meet spenddown.	Jones	N/A
11/8/95	More bills received ($617). Spdwn met approval notice sent	Jones	

For all Medicaid applications, the documentation on CMCC and/or the appropriate RAPIDS Screens must include, but is not limited to, the following:

- Date of application. This is on RAPIDS Screen ACPA.

- Date the verification checklist or ES-6 and 6A were mailed or given to the client. This appears on RAPIDS Screen CNHS.

- Date medical bills submitted by the client were received in the local office. This appears on RAPIDS Screen ANMR.

- Date medical expenses were added to RAPIDS. This appears on Screen AGTM.

- The result of each 30-day review found on CMCC (instructions in item 2 below).

- All actions related to the MRT process, when applicable, which include, but are not limited to:

  • Date initial medical reports are requested

  • Date of follow-up activity required to obtain initial reports

- Date medical reports are received in the county office
- Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
- Date of follow-up activity required to obtain the additional medical information
- Date additional medical reports are received in the county office
- Date material is referred to MRT
- Date the Worker is notified of the final MRT decision

This information appears on RAPIDS Screen ANMR.

2. Procedure For Review Of Pending Applications

Applications that have not been entered in the data system must be reviewed at least each 30 days.

The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. CMCC must document the reason the application has not been acted on. If this reason is not beyond the control of the Department, the Worker must immediately take any actions are necessary to process the application. If the application has not been acted on within the required time limit, the Worker must send an ES-20 or RAPIDS notice NMRL to the applicant informing him of the information which has not been received by the Department. The ES-20 or NMRL is sent to the client at the time of the expiration of the maximum allowable time for acting on the application.

D. DETERMINING REASONABLE PERIOD OF TIME FOR SPENDDOWN ENTRY

Cases that meet spenddown should be entered in the data system in the 30 day application period.

E. PRIOR ELIGIBILITY FOR CASES NOT CURRENTLY ELIGIBLE

When it is established that eligibility requirements for prior Medicaid coverage were met, but the case is not currently eligible, the procedures are as follows:

1. Approvals

The application is approved for Medicaid to cover the prior period. The medical card is mailed to the local office and is rewritten for the correct POE and mailed to the client. For a spenddown case, verified medical expenses, old unpaid bills prior to the POC, or paid and unpaid bills incurred during the POC, are used as spenddown expenses.
A manually written medical card for the correct POE is mailed to the client.

2. Denials

When the Worker determines that the case does not meet spenddown in the prior period, the application is denied and the client notified using the ES-NL-A.

3. Closures

Advance notice requirements apply. When the 13-day advance notice of closure is not required, the procedure is as follows:

If a card will be generated, the address of the county office is entered in ACCH.

A closure is transmitted immediately following the approval or spenddown transaction.

When the card is received in the county office, the Worker must destroy it and manually issue a medical card to reflect the prior POE. The Supervisor initials the card and either mails it or gives it to the client. It is the client's responsibility, or that of the individual who is acting on his behalf, to take the card to medical providers.

F. CHANGING COVERAGE GROUPS AND REDETERMINATION PERIOD

When one coverage group is closed and another opened, the original redetermination period is kept.