NURSING FACILITY SERVICES

17.9 INCOME

There is a two-step income process for providing Medicaid coverage for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid by being a member of a full Medicaid coverage group, by being a QMB recipient or by meeting a special income test. See Chapter 16 to determine which coverage groups provide full Medicaid coverage. If the client has a spenddown, it must be met before he is eligible for nursing facility services or it must be able to be met by the cost of the nursing facility. Once Medicaid eligibility is established, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. These processes are described in item D below.

A. EXCLUDED INCOME SOURCES

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 10.3 for the appropriate coverage group.

B. BUDGETING METHOD

See Section 10.6,B. A monthly amount of income is determined based on averaging and converting income from each source.

Regardless of the day of the month on which the client enters or leaves the nursing facility, all income the client is determined to have, according to Chapter 10, for each month he resides even one day in the facility must be counted in determining eligibility and in post-eligibility calculations. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

During the first month and last month that Medicaid participates in the cost of care, it is necessary to prorate the client's contribution to his care when he does not spend the full calendar month in the facility. This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other **nursing facility** resident who expects to remain in the facility a full month.

- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.

- Determine the number of days the client resided or expects to reside in the facility in the calendar month and multiply the number of days by the

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The request for consideration of a non-reimbursable medical expense must be submitted within 1 year of the date of service(s).

Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and

- An itemization of the services provided.

(2) Additional Limits for Expenses

For the items or services listed below, the following limits apply:

- Eye examination and eyeglasses - $300 in a 12-month period

- Eyeglasses - 2 pair in a 12-month period, unless medical necessity is established. The $300 limit in a 12-month period applies.

- Dentures - $3,000 in a 12-month period, unless medical necessity is established

- Hearing Aids - $1,500 in a 12-month period, unless medical necessity is established

NOTE: Medical necessity is determined by the Worker and/or Supervisor, based upon the documentation provided.

(3) Expenses Which Cannot Be Used

The following expenses cannot be used as a deduction for non-reimbursable medical.

- Durable medical equipment, unless purchased by the client prior to Medicaid payment for nursing facility services, and the cost was not reimbursable from any source

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- Bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved

- Medical expenses incurred during a period of Medicaid eligibility which are covered by Medicaid

- Nursing facility expenses incurred during a period of Medicaid ineligibility for excess assets, when the reason for excess assets is non-payment of the client contribution

- Co-insurance payments while the individual is Medicaid eligible and has Medicare or private health insurance

- Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance

- Charges incurred during temporary periods of Medicaid ineligibility when the reason is failure to complete a redetermination and the AG is subsequently reopened with no break in eligibility periods

- Nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved PAS

- Charges for bedhold days

NOTE: When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill from a nursing facility, a detailed itemization of the services must be provided. The itemization must include the date of the service or expense, the specific medical service, the reason no payment was received by the facility and the amount of the expense. Charges billed to Medicare, Medicaid or private insurance must be accompanied by an explanation of benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.