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The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum SMS. See Chapter 10, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up.

EXAMPLE: $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

NOTE: The FMA for each family member must not exceed one-third of the minimum SMS. See Chapter 10, Appendix A.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.

EXAMPLE: An individual is admitted to a nursing home for 6 months and then discharged to his home. His condition worsens after 4 months and he is readmitted to the nursing home again. He can receive the OLE again, if his physician certifies he is likely to return home again within 6 months.

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e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible, only as determined in items C,2, 3 or 4 above, certain medical expenses which are not reimbursable may be deducted in the post-eligibility process. These allowable expenses are listed in Section 10.22,D,11,c. Only the expenses of the eligible individual are used. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non-reimbursable from another source may be used as a deduction. Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. **This includes any portion of the Medicare Part D Premium that is not covered by the Low Income Subsidy (LIS).** The incurred expense must be the responsibility of the client.

NOTE: The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 4 for sources of insurance premium verification.

EXAMPLE 1: An institutionalized individual carries the insurance and pays the premium for himself and his community spouse. The institutionalized spouse receives a deduction for the full premium amount.

EXAMPLE 2: An institutionalized spouse, Mrs. Green, pays the premium for the insurance coverage that her community spouse, Mr. Green, carries for them both. The community spouse, Mr. Green, is admitted to the nursing facility. The insurance premium continues to be a deduction for Mrs. Green since she pays the premium.

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The total of all non-reimbursable medical expenses is entered in RAPIDS. The total amount is not rounded.

NOTE: For all AG's except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have

(1) Time Limits and Verification Requirements for Expenses

Applicants

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the 3 months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources.

EXCEPTION: A deduction may be given if there is evidence of a payment in the 3 months prior to application, even when the expense was incurred prior to that time.

EXAMPLE: Mrs. C applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the 3-month period, since there is evidence of a payment in the 3 months prior to application.

EXAMPLE: Same situation as above, except that Mrs. C did not make any payments during July, August or September. Since she did not incur the expense in the 3 months prior to the month of application or the month of application and made no payments during the 3-month period, no deduction is given.

Recipients

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

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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 **bed hold** 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.

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Post-Eligibility

Community Spouse Deduction:	$ 600.00	Shelter
	+ 366.00	SUA
	$ 966.00	Total Shelter/Utilities
	- 546.60	30% Min. SMS
	$ 419.40	Excess Shelter/Utilities
	+ 1,822.00	Min. SMS
	$ 2,241.40	
	- 950.00	Total gross monthly non-excluded income of Community Spouse
	$1,291.40	CSMA
Family Maintenance Deduction:	$1,822.00	Min. SMS
	- 585.00	Income
	$1,237.00	Remainder ÷ 3 = $412.33 FMA

$2,050.00	Income
- 50.00	Personal Needs
$2,000.00	Remainder
- 1,291.40	CSMA
$ 708.60	Remainder
- 412.33	FMA
$ 296.27	Remainder
- 158.50	Medicare premium and doctor bill
$ 137.77	Resource and total contribution toward his care

The client has a $137.77 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.