3455.15.10.20 LIABILITY DEVIATIONS (MED 1)

The policies in this section apply to the MA A, MA B and MA D categories of assistance.

A liability deviation allows unpaid medical expenditures, which are not covered by Medicaid or other third-party insurance, to be entered as a countable expense and temporarily lower the liability amount. Upon approval of a liability deviation request, the liability will be reduced giving the member the opportunity to pay the unpaid medical expense.

Members potentially eligible for a liability deviation include those who have a liability obligation and:

1. Reside in a Medicaid-certified long-term care (LTC) facility or
2. Are on an approved HCBS waiver

A member who does not have a liability obligation is not eligible to receive a liability deviation.

Documentation of the unpaid medical expenses is required and must include an actual provider generated bill, or a copy of such bill, which details the date(s) of service, type(s) of service, and clearly shows the amount that the member owes after any third-party payment, including Medicare. A medical expense which is already paid in full or was previously approved for a deviation cannot be deviated. The bill must clearly indicate who is responsible for the cost. If the member is not the party responsible, the liability deviation is not allowable.

If the dates of services for Medicaid covered expenses were during a month the member received Medicaid, the liability deviation cannot be approved. However, if a member was in a LTC facility and was on HIP, a deviation may be completed for medical expenses incurred in a retro month that the member was eligible for HIP coverage, if the claim was not a HIP covered service. Verification that HIP denied the claim is required. See section 2220.05.00 for additional information.

If the dates of service on the bill were during a transfer of property penalty period, the deviation request cannot be approved. Furthermore, if the member is currently in a transfer of property penalty period, a deviation is not allowable. See Section 2640.00.00 for additional information.

If the member has any Third-Party Insurances, including Medicare, who were not payors on the bill, verification from the insurer, which clearly documents the reason for non-payment, is required. Acceptable verifications include an Explanation of Benefits (EOB) documenting denial of payment or, in cases where the provider did not bill the insurer, documentation from the insurer showing that the specified services are not covered.

When documentation is missing or incomplete, the worker must send a written request which clearly advises the member, and their authorized representative(s) of the information needed and gives a deadline of 13 days from the date the request is mailed. The worker shall attach a

copy of the submitted deviation request to the Pending Verifications for Applicants/Recipients (DFR Form 2032).

If the member refuses or fails to provide the requested documentation within the designated 13-day period, the worker will, on the first day following the expiration of the 13-day period, mail a manual notice which indicates the reason for denial of the deviation request. Medicaid eligibility shall not be discontinued for failure to provide necessary documentation related to a deviation request.

If the requested information is provided, and deemed valid, the worker will take appropriate action to process the liability deviation. A deviation request calculator is available for worker use in *IEDSS Online Help* under Resources. A liability deviation is calculated as follows:

1. Divide the total allowable expense amount by the member's current liability amount to arrive at the length of the deviation. The number before the decimal is the total number of months where the member will have a $0 liability, also referred to as "whole months."
2. Multiply the whole number of months by the member's current liability amount to arrive at the amount of the expense that will be paid in the months with $0 liability.
3. Subtract the amount of expenses that will be paid in the whole months from the total allowable unpaid expense amount. The remaining amount of the expense will be used to reduce the liability for the final deviation month, also referred to as "partial month."

Liability deviations are processed according to change reporting guidelines and are regarded as a positive change. The effective date of the change is the first of the month following the month in which the change was both reported and verified. If the Eligibility System does not form the correct reduced liability of as of the first following month, then the case should be reviewed for a possible liability override or fiat. Refer to sections 2220.00.00 through 2220.20.00 for additional information. Once the liability deviation has been processed and the change authorized, the worker must send manual notice indicating approval of the liability deviation request.

Examples of allowable medical expenses that can be deviated include (but are not limited to):

- Room and Board for nursing home level care
- Unpaid medical bills incurred prior to Medicaid eligibility

Examples of nonallowable medical expenses include (but are not limited to):

- Ancillary services or products, such as gloves and tissues
- Long term care services during a transfer of property penalty period
- For HCBS waiver members, non-medical care such as companions, attendants and homemakers that are not deemed medically necessary under the waiver care plan
- Copayments for dual eligible members
- Over the counter medication

- Medical bills already paid by the applicant, member or a third party
- Assisted Living expenses

Any questions about validity of a liability deviation should be sent to PAL for review.