

## MMIS WebEx Questions and Answers from April 2012

- I. Foster Care Eligibility; 18 year old ending FC-Do you evaluate for other covered groups?

### Q&A response-

Yes, evaluate MI under 19 years of age, <21 year old group; if disabled, follow normal procedure if a disability determination needed. Process down as you would for any other Medicaid member.

- II. If SSI member, 48 years old, loses SSI and is now Title II SSA Disability Benefit with no Medicare (i.e., in waiting period)-Do you evaluate for Plan First?

### Q&A response-

Yes, process down as you would for any other Medicaid member. Additionally, this individual could be MN only and placed on 2 consecutive spenddown periods.

- III. If a case is closed as the renewal could not be completed would you evaluate for Plan First?

### Q&A response-

If no review form AND you cannot do an ex parte renewal or phone renewal AND you do not have verification of income you cannot evaluate.

- IV. MI child less than 19 years of age is now SSI eligible; do you place the child in a separate case?

### Q&A response-

Local agencies separate Medicaid caseloads in different ways. While it is not necessary that an SSI child be placed in a separate case, some agencies place SSI members in separate cases. It is up to the individual agency.

- V. Member has TPL and indicates it is not valid; the other sibling has TPL and is not in Medicaid; can the TPL be deleted or end dated?

### Q&A response-

First of all, it does not matter what the non-Medicaid sibling has as far as coverage, our only concern is the Medicaid eligible sibling. You must determine if the coverage was valid at any point in time or if it was added in error as belonging to the child. If in error delete the policy,

## MMIS WebEx Questions and Answers from April 2012

if ended then end date the policy and the coverage under the policy with the date the policy terminated, as it was valid coverage at one time.

VI. An SSI member's authorized representative moves, should you transfer the case?

### Q&A response-

**No, the agency that handles the case is the one where the member resides not the authorized representative.**

VII. Worker received a phone call from a provider who indicated that a member's name needs to be changed in the MMIS; do we change the name?

### Q&A response-

**The name in the MMIS must be the name that SSA has linked to the SSN. The only time the name is changed is if it is a legal name change and it can be verified with SSA that the name has been changed.**

VIII. Do you add Medicare Supplement insurance plans to the member's TPL or MMIS?

### Q&A response-

**Yes, supplement plans are added as TPL; Medicare Advantage Plans, known as Medicare Part C, are NOT added to the system, only Medicare Part A and B are added. Please note workers are not to change Medicare coverage in the MMIS, contact the [Buyinunit@dmas.virginia.gov](mailto:Buyinunit@dmas.virginia.gov) for assistance.**

IX. Member was enrolled in Plan First, returned her renewal forms and is now eligible for full coverage; how do you move them back to full coverage?

### Q&A response-

**If there is no break in full coverage, send a coverage correction form to the enrollment unit to void out the Plan First coverage. There is a system issue with the MMIS that causes loss of coverage because Plan First coverage in this situation would be ended the date it began. By having DMAS void the coverage line, the member will not face an interruption in coverage and providers will be able to be paid for any claims on that date. We expect a programming change this summer that will prevent this issue.**

## **MMIS WebEx Questions and Answers from April 2012**

- X. An individual has renal failure and has applied for Medicaid. The individual provides a doctor's statement attesting to this condition. How are they enrolled in the MMIS?

### **Q&A response-**

**An SSA disability determination must be completed in order for this person to be considered as a disabled individual for Medicaid purposes if they meet no other Medicaid full coverage covered group.**

- XI. Where do you find a list of reinstate codes for the MMIS?

### **Q&A response-**

**MMIS screen help provides a list. There are only 3 codes, 001, 002 and 003. Reinstatement code 003 is used for all reinstatement transactions that are done directly in the MMIS and do not involve appeals. ADAPT sends over 001, but it is not the correct code and a Medicaid appeal does not apply in that instance.**

- XII. Medicaid eligibility policy no longer references a signed renewal form; they can now be completed by telephone interview. Under what circumstances would you cancel this member?

### **Q&A response-**

**If ex parte is not appropriate for the case and you cannot complete by telephone, send a renewal form; if no response, then cancel the member.**

- XIII. LTC patient pay deduction for dental-charging \$165 dollars for sonic cleaning dentures once a month and other similar services; is the service a valid patient pay deduction? Additionally, they want the adjustment in advance of the service.

### **Q&A response-**

**Remember that patient pay deductions must be for a non-covered medical service. Patient pay deductions are not done prospectively, they are done after the service has been provided. Chapter M1470 provides a list of services that are not allowed as deductions, page 12, M1470.230C.2e3. Refer to 4b of this section for documentation requirements for deductions for non-covered medical services. Due to the nature of the providers' contact with the LDSS and the types of services for which they were requesting patient pay adjustment, it was requested that the LDSS fax the information to the Policy Division at DMAS after processing.**

## **MMIS WebEx Questions and Answers from April 2012**

XIV. For ABD renewal is verification of resources still required now that telephone interviews can be completed?

### **Q&A response-**

**Yes, verification is still required.**

XV. Is there a new listing for aid categories, worker was told AC 074 was not valid.

### **Q&A response-**

**The listing of ACs can be obtained through screen help off the eligibility screen in MMIS. AC 074 is still a valid AC for IV-E AA and FC children at this time.**

XVI. Is podiatry a valid patient pay deduction for a NF member?

### **Q&A response-**

**You must first determine if the service was medically necessary. Refer to M1470.230.Ce3-4.**

XVII. Can you reinstate a member who was canceled using Cancel code 001 due to death?

### **Q&A response-**

**Yes, just reinstate as you would any other member.**

XVIII. When will "income list" on SPARK be updated?

### **Q&A response-**

**This is a document that is owned by VDSS; therefore, the Medical Assistance Unit is responsible for update. Remember that the income limits are in M07 and M08 of the Medicaid manual.**

## **MMIS WebEx Questions and Answers from April 2012**

XIX. Member claims no TPL, but there is TPL listed in the MMIS. Can it be deleted?

### **Q&A response-**

If it is Medicare, you must contact the Buy-in Unit at DMAS. If you can verify that the TPL did not exist for the member, you may delete the policy. If the policy was entered by the DMAS HIPP Unit you must contact them at [HIPP@dmas.virginia.gov](mailto:HIPP@dmas.virginia.gov) . If you cannot verify the validity of the policy contact the DMAS TPL unit at [TPLunit@dmas.virginia.gov](mailto:TPLunit@dmas.virginia.gov) and they will research.

XX. Can DMAS share the PowerPoint of this presentation with VDSS?

### **Q&A response-**

DMAS has shared the presentation and VDSS is pending making the appropriate changes to allow LDSS to view through the knowledge center. All presentations will be shared with the VDSS and LDSS.

XXI. Client in a NF for a temporary stay. Can the member return to QI coverage after they leave the facility?

### **Q&A response-**

Yes, you must evaluate the member's eligibility when they leave the facility to determine if eligibility may continue in any covered group.

XXII. What renewal form can you use for Plan First?

### **Q&A response-**

Any form that provides the information needed to complete the renewal. Remember, a resource evaluation is not required for Plan First, so you would not want to request information for something that is not required. There would be no need to start with the ABD renewal form, but it would be valid if received.

## **MMIS WebEx Questions and Answers from April 2012**

XXIII. Does a payee for SSA or SSI need to validate provide proof that they are the authorized representative for the member?

### **Q&A response-**

**Yes, the individual must verify they are the authorized representative by normal Medicaid procedures.**

XXIV. What is QMB extended?

### **Q&A response-**

**This is a term used by the federal government and some states for full coverage, dual eligible members.**

XXV. Can the new fraud referral form that was announced in Broadcast 7373 be updated to be more user- friendly? The form moves when you try to type on it.

### **Q&A response-**

**This suggestion will be forwarded to the DMAS Recipient Audit Unit for review.**

XXVI. If a PG member has a miscarriage, does it need to be verified?

### **Q&A response-**

**No, accept the member's statement, but remember to evaluate the member for eligibility in any other Medicaid covered group for which they meet the definition including Plan First.**

XXVII. In reference to slide 23 of the presentation which states "If patient pay is zero and a CBC enrollee switches between different services, it is not necessary to change the provider"; is this still correct when a new 225 is received?

### **Q&A response-**

**Yes. The personal care to respite is a good example and the situation we see most often. The stop and start of these services is distinct and different than receiving more than one service at a time and a situation where the member leaves the provider and does not return, as they would in the example. The member would go back to personal care.**

## MMIS WebEx Questions and Answers from April 2012

XXVIII. How does DMAS find out that a member has a TPL? Is there a report that can be shared?

### Q&A response-

No, there is not a report. DMAS discovers TPL's when the member provides the TPL information to their medical provider and claims are received.

XXIX. All claims are being denied for non-pregnancy related services for my member, what should I do?

### Q&A response-

If the provider is calling, refer them to the call the provider helpline. The helpline will be able to research the denial reason codes and assist the provider. If the member is calling, refer them to the member helpline for assistance with claims.

XXX. A client under the age of 65 applied for benefits and requested retro coverage, however, verification of resources was not provided by the applicant. The worker evaluated and approved the member for Plan First coverage in the retro period. After the 45 day processing timeframe had passed, the member submitted the verifications and requested to be evaluated for SLMB coverage. Does the agency need to reevaluate this member retroactively?

### Q&A response-

No, if the 45 day processing period has passed and the agency has already evaluated the retro period and made a decision, the coverage is not reevaluated. The agency should evaluate prospectively.

XXXI. A member has a life insurance policy that has a \$7,000 cash value. He wants to set aside \$3,500 for himself and \$3,500 for his spouse. Can he do this if he is the sole owner of the policy?

### Q&A response-

You can exclude up to \$3,500 each in funds set aside for the burial expenses of the individual and the burial expenses of his spouse (M1130.410 C. 1). While there is a requirement that burial funds cannot be co-mingled with non-burial funds (M1130.410 C. 3 and M1130.410 E. 2), there is no requirement that there must be a separate financial instrument for each individual. When designating a life insurance policy as a burial fund, it is the policy that is designated (M1130.410 D. 5). If the life insurance policy has a cash surrender value of \$8,000,

## MMIS WebEx Questions and Answers from April 2012

then up to \$3,500 can be set aside for the applicant/recipient and \$3,500 for the spouse which leaves \$1,000 as a countable resource. Burial fund set asides must be verified at every renewal (M1130.410 F. 1) so we can determine if any of the funds have been used and the countable amount that is not excluded (see M1130.410 F.1).

XXXII. A 17 year-old member has an EDCD Waiver due to injuries sustained in a car accident. The member's school has requested that an iPad be purchased for the child in order to assist with educational needs and rehabilitation. Will Medicaid cover the purchase of an iPad?

### Q&A response-

This may be a covered service if it is shown to be a medical necessity for this member. The provider should request coverage through EPSDT. Brian Campbell of DMAS can be emailed with questions at [epsdt@dmass.virginia.gov](mailto:epsdt@dmass.virginia.gov).

XXXIII. Is a client required to be enrolled in Medicare if they are eligible?

### Q&A response-

If the member has Medicare Part A they are immediately enrolled in Medicare Part B per federal policy. If you have a situation where the member has not been enrolled in Part B contact the DMAS Buy-In Unit at [medicarebuyin@dmass.virginia.gov](mailto:medicarebuyin@dmass.virginia.gov) or by phone at (804) 786-7414 or (804) 371-8888.

XXXIV. When is the member helpline going to be a toll-free number?

### Q&A response-

There are no plans for a toll-free number at this time.

XXXV. Two children on the same caseload have been enrolled in two different MCO's. The parent wants the children on the same MCO. Why were they enrolled in different MCO's and how can it be fixed?

### Q&A response-

The case head would have received a letter advising of the MCO assignment and would have had an opportunity to call and have this changed. Advise the parent to call 1-888-643-2273 to have the MCO updated.

## **MMIS WebEx Questions and Answers from April 2012**

XXXVI. A PG Medicaid member advised the worker that she has an ectopic pregnancy. Does the worker wait until the member provides proof that the pregnancy has been terminated or should the PG eligibility be closed in 60 days?

### **Q&A response-**

**The member needs to report the end of the pregnancy ten days after the change occurs. At that time, the closure would be handled the same as the end of a regular pregnancy and the member should be evaluated for any other applicable coverage.**

XXXVII. Why is a member dropped from a MCO without warning? Members go to the doctor and find out they are no longer enrolled in the same MCO.

### **Q&A response-**

**When DSS makes changes in eligibility the member can be dropped from the MCO. For example, if the member completes their renewal late and their eligibility is scheduled to close and the closure is not rescinded until after the 18<sup>th</sup> of the month (MCO cut-off) then the member will be dropped from the MCO. Reassignment to a MCO never occurs retroactively, even when the Medicaid eligibility is retroactive.**