

**Table of Contents**

**APPENDIX 700, MEDICAID CLASSES OF ASSISTANCE**

|  |       |
|--|-------|
| 700 - MEDICAID CLASSES OF ASSISTANCE ..... | 700-2 |
| 710 - ELIGIBILITY CERTIFICATIONS .....     | 700-4 |
| 720 - ELIGIBILITY CARDS .....              | 700-8 |

**APPENDIX 700 - MEDICAID CLASSES OF ASSISTANCE**

Medicaid workers use several categories of Medicaid coverage to determine eligibility. The DFCS Medicaid Eligibility Specialist determines eligibility and cost share for the following categories. **EXCEPTION:** Supplemental Security Income (SSI) Medicaid.

\$ Supplemental Security Income (SSI) Medicaid: Individuals receiving an SSI check usually receive SSI Medicaid automatically. A person applies for SSI financial assistance at the Social Security Administration. To be eligible for SSI, a person must meet certain eligibility criteria and have income and assets within established limits. The Medicaid number is the client's social security number followed by the suffix AS. An SSI Medicaid client does not have a potential to cost share.

\$ Community Care Services Program (CCSP): Requirements and procedures for this class of assistance are discussed in Section 510, CCSP Medicaid Eligibility.

\$ Public Law 94-566: Medicaid for individuals who have received SSI but are terminated from SSI because of a cost of living adjustment in their Social Security benefits after 1977. Any client whose SSI benefits are terminated, due only to an increase in Social Security, continues to be eligible for Medicaid benefits under this law. The Medicaid number is nine digits followed by the letter "P". If these clients enter CCSP, they have a potential to cost share.

\$ Deeming Waiver (Katie Beckett): Medicaid for chronically impaired individuals under age 18 who are nursing home candidates but could receive less costly care at home. These individuals are ineligible for SSI because of their parents' income or resources. The Medicaid number begins with the county suffix followed by six digits and ends with 1D00. If these clients enter CCSP, they begin to receive CCSP Medicaid and have a potential to cost share. Katie Beckett Medicaid clients cannot be in both categories of Medicaid at the same time.

\$ Medical Treatment Facility (MTF): Medicaid for individuals residing in nursing homes and hospitals for at least 30 days. A MTF individual may have income higher than the SSI limit. The Medicaid number is nine digits followed by the letter "P." These clients have a potential liability to the nursing home but not the hospital.

DFCS offers other Medicaid classes of assistance. When any doubt arises about potential Medicaid eligibility, the care coordinator refers the client to the DFCS office in the county of residence.

The following is the DFCS standard of promptness (SOP) for determination of Medicaid eligibility:

\$ Aged (individuals 65 years of age or older) - 45 days

\$ Disabled (individuals who receive social security disability or meet the disability criteria

for social security benefits) - 60 days

The SOP starts with the date DFCS receives the signed Medicaid application. The care coordinator sends the CCC, PMAO Financial Worksheet, and the LOC page to DFCS but receipt of these forms does not establish an application date for Medicaid at DFCS. The client files a Medicaid application at DFCS or the care coordinator may send the signed application to DFCS with the CCC, PMAO Financial Worksheet, and LOC page.

DFCS considers Medicaid eligibility for three months prior to an application for SSI and Medicaid classes as assistance.

## 710 - ELIGIBILITY CERTIFICATIONS

The DMA contracts with the DHR's Division of Family and Children Services (DFCS), and the federal SSA to perform eligibility determinations. The policies for determining eligibility are based on federal law and are provided to the DFCS by the DMA. The groups of individuals eligible to receive Medicaid benefits in Georgia are listed in Part I, Chapter 100, Section 113 of the *Policies and Procedures Manual Applicable to all Medicaid Providers*.

The Medicaid certification, or card, is an 8 2 Ax 11" sheet of paper. The Medicaid card is issued monthly to the head of household when multiple recipients in the household are eligible, or to an individual recipient. The cards list the names and individual recipient numbers for all family members eligible for Medicaid. *\*\*The care is valid only for the period indicated thereon and should be examined on each occasion when a service is requested to ensure that the recipient is currently eligible.* There are four types of Medicaid eligibility certification cards. Each certification is different in color and title. They are:

### **Medical Assistance Eligibility Certification:**

(Goldenrod in color)

\$ The most commonly seen Medicaid card

### **Medical Assistance Medicare Cost Sharing Eligibility Certification:**

(Cherry in color)

\$ Medicaid reimbursement only for Medicare premiums, coinsurance and deductibles

\$ Recipients referred to as Qualified Medicare Beneficiaries (QMBs)

\$ Medicaid ID number ends in AQ@

### **Medical Assistance Presumptive Eligibility Certification:**

(Sky Blue in color)

\$ This certification is a temporary care for pregnant women who are awaiting eligibility determination on their regular Medicaid application

\$ Eligible for all Medicaid services, except inpatient hospital services and delivery procedures

\$ Medicaid ID number ends in K

### **Medical Assistance Eligibility Certification Georgia Better Health Care:**

(Lime Green in color)

\$ Recipients are assigned a primary care physician (PCP)

\$ Services may require authorization from the PCP

The Medicaid card provides the following information:

\$ Current month of eligibility

\$ Recipient name

\$ Recipient's Medicaid number

- \$ Date of birth
- \$ Other medical coverage (commonly known as third party)
- \$ Pharmacy record
- \$ Record of annual limitations

### **Regular Georgia Medicaid Eligibility:**

A reproduced facsimile should not be accepted as proof of eligibility. The bottom right hand corner of the card indicates to providers those recipients who have met certain program limitations. When a recipient reaches a service limitation that the Department (DMA) has established, it will be indicated on each subsequent card.

To determine which recipient has met the limitation, match the ID number next to the specific limitation in this section to the same ID number printed in the column to the left of the recipient's name in the middle section of the certification. Since the Department cannot control or anticipate the flow and number of clients submitted, these records are for information purposes only and cannot be regarded as official records for the purpose of receiving reimbursement for a service which would exceed any program limitation. The recipient, not the Department, would be responsible for the payment of services exceeding any monthly or annual limitation.

The perforated lower left portion entitled "Georgia Medicaid Pharmacy Record" is for pharmacy providers only. This portion will be removed and retained by the pharmacist who dispenses the recipient's first prescription of the month; therefore, this portion of the card may be missing when presented, but the card is still a valid certification. The word 'LIMITATIONS' appears just below each recipient's name on the "Georgia Medicaid Pharmacy Record". For those drugs that have limitations on length of therapy, an alphabetic code will appear after the word 'LIMITATIONS' once the limit has been reached. The explanation of codes is as follows:

### **LIMITATIONS:**

- H Recipient has received 60 days of therapy with an H2-Receptor Antagonist.
- S Recipient has received 60 days of therapy with Sucralfate.
- A Recipient has received one prescription for a single-source NSAID.
- L Recipient has received 60 days of therapy with a proton pump inhibitor.
- C Recipient has received on prescription of Dolobid or Toradol injection (without prior approval per calendar year. All Toradol tablets require prior approval.
- R Recipient has received one prescription of a non-sedating Antihistamine/decongestant without prior approval.
- E. Recipients over 21 years of age must have a prior approval to receive these generic Lorazepam, Oxazepam and Clorazepate Dipotassium.
- J Non Preferred Drugs
- M Recipient has received duplicate antidepressant therapy for one month.
- F Recipient must have a prior approval to receive a brand name innovator product.

Recipients who have reached multiple limitations will have multiple codes appearing after the word ALIMITATIONS@. In order for recipients to continue to receive the drugs beyond the prescribed limitations, the attending physician must request approval on the DMA Prior Approval Drug(s) Request Form, DMA-614.

### **Qualified Medicare Beneficiaries (QMBs) Eligibility**

Benefits for individuals eligible for Medicaid only as Qualified Medicare Beneficiaries (QMBs) are limited to assistance for Medicare cost sharing expenses, which are premiums, deductibles, and coinsurance under Part A and Part B of Medicare. No other services are included for Medicaid reimbursement. QMBs will receive a cherry colored (hot pink) Medicare Cost Sharing Eligibility Card each month as evidence of eligibility. The cards are valid only for the period indicated thereon and should be examined on each occasion to ensure that the individual is currently eligible. A reproduced facsimile should not be accepted.

### **Presumptive Eligibility**

Presumptive eligibility is an expedited process of enrolling eligible pregnant women in the Medicaid program. It allows certain providers, designated as qualified providers, to make a preliminary Medicaid eligibility determination on behalf of a pregnant patient. All Medicaid services except inpatient hospital services and delivery procedures are covered. The Presumptive Eligibility Card is blue in color.

### **Georgia Better Health Care (GBHC)**

GBHC is a program based on a type of coordinated care called primary care case management. Each Medicaid recipient selects or is assigned to a primary care physician who is responsible for coordinating that recipient's health care. As case managers, the primary care physicians authorize their Medicaid recipient's medical care, including referrals to specialists, inpatient and outpatient hospital services, lab work, etc. The GBHC card is lime green in color.

### **Third Party Liability**

Providers should reference Section 104.2, Section 201.3(b), and Section 303 in Part I of the *Policies and Procedures Manual Applicable to all Medicaid Providers* for information on third party liability. At the time the Medicaid information is obtained from the recipient, a provider should determine if additional resources exist. These resources must be identified on the Medicaid claim form and must be utilized before filing a claim with Medicaid.

Providers can make a significant contribution to Medicaid in the area of third party liability. Since providers have direct contact with recipients, they are the best source of timely third party liability information. Providers have an obligation to investigate the report of existence of other insurance or liability since Medicaid is the payer of last resort. Cooperation is essential to the proper functioning of the third party liability subsystem.

The Medicaid card lists known third party resource information for each recipient. The “Type Indicators” on the card denote the type of insurance coverage the recipient has. If a recipient requests services for which a third party carrier is liable, the carrier must be billed prior to billing Medicaid. If and when the third party denies the claim or remits partial payment, the provider may then submit a claim to Medicaid. The claim must indicate the third party payment received. If there are multiple insurance carriers, a copy of the remittance advice or explanation of payments from each source must be attached.

Source: *DMA Billing Manual for Community Care Services, Revised 7/1/98*

**720 - ELIGIBILITY CARDS****▪ Head of Household:**

This is the person to whom the card is mailed. Refer to the section entitled “Person(s) Eligible” for eligibility information.

**▪ Person(s) Eligible:**

Listed in this section are recipients eligible for Medicaid Services.

**▪ Medicaid ID Number:**

Each recipient in the household is assigned their own Medicaid number.

**▪ Month of Eligibility:**

The month and year of eligibility are the month and year of eligibility.

**▪ Other Medicaid Coverage:**

This section indicates primary insurance coverage. Type of coverage indicators are defined on the back of the card. The carrier code can be used to obtain the name and address of the primary insurance (Refer to the Third Party Carrier Listing provided by DMA).

**▪ Service Limitations:**

This section details any limitations the recipient has reached.

**▪ Pharmacy Record:**

This section is used solely by pharmacy providers to record prescription activity during the month for the recipient. Pharmacy providers may detach this portion of the card. A card with the pharmacy record removed is valid. MCO enrolled recipients receive all of their prescription medications from an MCO network pharmacy.

Source: *DMA Billing Manual for Community Care Services, Revised 7/1/98*

## **INSERT**

### **ELIGIBILITY CARDS**

(1 page back and front

1 page front only

1 page back and front

1 page back and front

1 page front only & 1-sided pages)