



APPLE HEALTH (MEDICAID) MANUAL REVISION

Revision #	070
Chapter / Section	Allowable Medical Expenses Washington State Health Care Authority
Issued Date	8/1/2022
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[Allowable Medical Expenses | Washington State Health Care Authority](#)

Summary of Revision

Revision are made to update waiver language to current terminology, removed examples

Apple Health (Medicaid) Manual revision via track changes:

Attach PDF of the word document with track changes.

Allowable Medical Expenses

Revised Date:

September 8, 2014

Purpose: This section gives a listing of allowable medical or remedial services and expenses that are allowed to reduce participation or used in MN spenddown. This is not a complete list, but an aid to use when to determine whether a claimed medical expense is allowed to reduce participation or used to meet spenddown.

Medical Expenses Specific to Long-Term Care

WAC [182-513-1350](#) (6) (b) gives the criteria for allowable medical expenses used to reduce excess resources. [DDA Waivers](#), [HCBS CN Waivers](#), Hospice and participation rules point to this WAC as to allowable out-of-pocket medical expenses.

- Premiums, deductibles, and coinsurance/copayment charges for health insurance and Medicare premiums
- Necessary medical care recognized under state law, but not covered under the state's Medicaid plan;
- Necessary medical care covered under the state's Medicaid plan incurred prior to Medicaid eligibility.
- Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to
- As long as the incurred medical expenses:
 - Were not incurred more than three months before the month of the ~~m~~Medicaid application;
 - Are not subject to [third-party payment](#) or reimbursement
 - Have not been used to satisfy a previous spend down liability

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- Have not previously been used to reduce [excess resources](#)
 - Have not been used to reduce client responsibility toward cost of care
 - Were not incurred during a transfer of asset penalty described in WAC [182-513-1363](#).
 - Are amounts for which the client remains liable.
- Expenses not allowed to reduce excess resources or participation in personal care are:

- Unpaid expense(s) prior to HCBS Waiver eligibility to an adult family home (AFH) or boarding home is not a medical expense.
- Personal care cost in excess of approved hours determined by the CARE assessment described in [106 WAC](#) is not a medical expense

Covered Items Under Medicare, Medicaid or a Medicare/Medicaid Managed Care Plan is not an allowable Deduction From Participation

Medical services covered by Medicare, Medicaid or covered under a Washington Apple Health (WAH) - managed care plan is not an allowable deduction from ~~Long-term care~~ participation because it is considered "covered". [Washington Apple Health \(WAH\)](#) - ~~Managed care~~ is formally known as Healthy Options (HO). If the client's medical practitioner indicates an item or service is medically necessary and the item or service is denied, the client must file an appeal with Medicare, Medicaid or the WAH managed care plan. The reduction of participation is the last resort after all other resources are pursued. Most medically necessary items should be covered by either ~~Medicare~~, ~~Medicaid~~ fee-for-service or WAH managed care under the [scope of care](#). This includes [transportation cost](#), [over the counter items](#), [cough and cold products](#), [vitamins](#), [topical](#) and [durable medical equipment and supplies](#), [incontinent supplies](#), foot care, [hearing aids](#), that are covered by Medicare, Medicaid or WAH managed care. See: [Long-term care and WAH managed care](#) See: [Long-term care insurance and third party resources](#).

What if a client chooses a non-~~Medicare~~/~~Medicaid~~ contracted provider?

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If a client chooses to go to a non-~~m~~Medicaid contracted provider or outside the Washington Apple Health (WAH) managed care network, the charge is the client's responsibility as the service is covered under their ~~m~~Medicare, ~~m~~Medicaid or WAH managed care plan. Health Care Authority (HCA) has an agreement to pay for health care services that is signed by the provider and client. HCA 13-879 The exception is when a client has "creditable" insurance coverage through their retirement, pension, employer sponsored plan or COBRA continuation plan. These client's may have copayments. These copayments are an allowable deduction only if Medicaid does not pay the copayments due the provider not having a Medicaid contract. Individuals with creditable insurance coverage are not limited to Medicaid contracted providers. An exception to rule (ETR) may be requested through the HCS Regional Designee for HCS cases or Marcie Birdsall for DDA cases if a client goes out of network due to special circumstances.

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Health Care Authority links - What is covered under Medicaid?

- [Scope of care chart](#)
- [Pharmacy information](#)
 - Drug lists
 - Over the counter lists including cough/cold, vitamins
- [WAH managed care](#) (Formerly called Healthy Options) [covered services page](#) lists covered items. Rule of thumb, if it is covered under Medicaid it should be covered under WAH managed care.
- [Durable medical equipment](#).
- Non covered services are an allowable deduction from participation.

What if the item is covered, but there is no contracted provider in the area?

There are situations where a needed contracted ~~m~~Medicaid provider is not available within a reasonable distance. The most common situation is when a client is unable to find a ~~m~~Medicaid contracted dentist within a reasonable distance.

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An exception to rule (ETR) may be requested. The reasoning must be documented. A medical expense is not allowed at the private rate if the care/expense is available under the ~~m~~Medicaid rate.

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ETR requests for a medical deduction that is listed as a covered item under ~~m~~Medicare, ~~m~~Medicaid or HO must go through the HCS Regional Financial Program Manager for HCS offices. For DDA cases, an ETR request to reduce participation for a covered item must go through HCS ~~HQ~~ Marcie Birdsall.

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Example: An exception to rule (ETR) can be considered for any medically necessary expense to reduce participation if an item is needed right away and the client has requested an appeal through Health Care Authority, Medicare or the WAH managed care plan. ETRs are forwarded to the HCS Regional designee (Financial Program Manager). DDA LTC Specialty unit ETR requests are forwarded to ~~Marcie Birdsall.~~

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Incontinence supplies

A common expense turned in as a participation deduction is incontinence supplies.

Incontinence supplies are covered under Medicare/Medicaid. If the client is in need of more supplies than normally allowed, a medically necessary justification may be requested by Medicare or Health Care Authority in order to authorize more supplies.

Do not allow incontinence supplies as a participation deduction.

Medication organizers/bubble packing

Bubble-packing prescription drugs is not an allowable expense from participation.

Facilities such as adult family homes, assisted living and nursing facilities have specific regulations that ensure the proper labeling and organizing of a client's medication.

If a facility chooses to send the medications to a vendor to be bubble-packed, it is not an allowable deduction from participation.

What does Medicare cover?

Individuals on Medicare and Medicaid are called Full Benefit Dual Eligible (FBDE). Individuals on institutional ~~and Medicaid~~ and HCB waivers do not have copayments toward ~~Medicare~~ services.

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Individuals on institutional and HCBS [waiver](#) services on Medicare D for prescription drugs may have a premium cost that is an allowable medical deduction if the client has chosen a non benchmark Medicare D PDP.

Drugs that are allowed under ANY PDP formulary under Medicare D, but not allowed in the specific PDP the client has chosen is not an allowable deduction from participation. Guidance from CMS has indicated if the drug is in any formulary it is a covered item.

Individuals on "credible coverage" for prescriptions are not enrolled in Medicare D. Prescription copayments due to credible coverage insurance is an allowable medical deduction from participation.

[Medicare has a web tool to check for covered items under the Medicare program.](#)

[CMS notice to providers regarding QMB and Medicaid](#) eligible clients. Providers are not allowed to charge QMB clients copayments.

If you have an institutional or HCB Waiver client being charged a Medicare D copayment, refer them back to the provider and indicate if the provider doesn't refund the copayment, the client will need to call the [1-800-MEDICARE helpline](#).

LTC and Medicare C and D charges

[Medicare Programs](#) describes Medicare programs, buy-in, Medicare buy-in unit contact information, what is Medicare and the different Medicare programs. This includes information on Medicare A, B, C and D and referral numbers for help on Medicare related issues.

[Medicaid Covered Drugs for Part D Dual Eligible](#)

[CMS guidance on expenses related to Medicare D](#) for spenddown

[Medicare and Long-Term Care](#) link has detailed information on Medicare and long-term care including participation issues.

[Medicare and spenddown](#)

Medicare premiums and LTC overview

Once a LTC client is eligible for Medicaid, the Medicare premiums are paid.

Allow a ~~Medicare~~ Medicare premium deduction that is considered out-of-pocket to the client. Don't allow a Medicare premium that will be covered under a Medicare Savings Program (MSP) or a state buy-in program.

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S05/SLMB eligibility is effective up to 3 months prior to the date of application if eligible.

S03/QMB eligibility is effective the first of the following month the client is determined eligible. Allow the Medicare A/B premium as a participation reduction in the month(s) prior to the S03 opening.

Medicare D/Low income subsidy is for all active MSP or Medicaid clients. It is effective immediately. Client's can choose a nonbenchmark plan which may have additional premium costs that is allowed as a participation deduction. Institutional and HCBS Waiver clients have no ~~Medicare D~~ Medicare D copayments.

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For individuals not eligible for a Medicare Savings Program (MSP), it takes approximately two months before the department begins paying state buy-in. Allow the Medicare A/B premium as a participation reduction. This should only occur when there is a retro or historical opening prior to MSP eligibility.

For questions related to insurance or Medicare premium payments, contact HCA Coordination of Benefits section at 1-800-562-3022 EXT: 1-6129 or [email](#).

If using the [contact us email](#), use the client button. Indicate your contact information and question. Indicate you are a financial worker and your office. Include the ACES client ID.

HCA no longer pays Medicare C premiums with the exception of a small existing caseload subject to funding (these cases were grandfathered for Medicare C payment).

Spenddown

For more information on Medical Spenddown such as base periods, medical transportation, public programs and ACES screens see [Spenddown](#)

The spenddown clarifying information gives guidance as to allowable medical expenses:

[What about expenses paid with a credit card](#)

[What about expenses sent to a collection agency.](#)

What are the differences between expenses allowed to reduce participation and those used in MN spenddown?

The medical expense chart used for MN spenddown is the same basic guideline used to reduce participation for LTC programs.

There are situations that are unique to long term care programs.

- Expenses incurred during a LTC [transfer penalty](#) are not allowed to reduce participation.
- For LTC, a medical expense prior to eligibility must be unpaid. For spenddown, expenses incurred and paid 3 months prior to the application can be used.
- Private personal care cost in excess of approved hours determined by the CARE assessment described in [106 WAC](#) is not a medical expense.
- Unpaid expenses prior to HCBS Waiver eligibility to an adult family home (AFH) or boarding home is not a medical expense. This applies to both participation and MN spenddown. These facilities are not medical facilities. Another term for AFH and boarding homes is alternate living facility (ALF).
- Expenses of the community spouse or family members. This includes health insurance premiums. If the health insurance premium is for the couple, we allow one half of the expense for the LTC recipient if we are unable to determine the amount of the LTC recipient's share.
- Health insurance premiums paid by a 3rd party including HCA COB unit are not used to reduce participation. Health insurance premiums paid on a client's behalf by COB are considered an income deduction for the MN Spenddown program.
- Medical expense deduction from participation that is a covered item under the state plan is not allowed as a deduction if the client was on Medicaid during the date of service.
- Medical expense deduction for copayments or deductibles from participation that is a covered item under Medicare is not allowed as a

deduction if the client was on Medicaid and QMB during the date of service.

- Medical expense deduction from participation that is a covered item under the [Managed Care](#) plan (formerly Healthy Options) is not allowed as a deduction if a client chooses the service outside of the Healthy Options network.
- Liquid supplements (such as Ensure, Resource) are covered by HCA Medicaid when medically necessary. Liquid supplements (enteral nutritional products) not approved by HCA are not considered a medical expense used to reduce participation even if the client has a medical prescription.
- Effective 11/22/2012 reasonable limits on allowable medical expense deductions described in WAC [182-513-1350](#) was final.
 - Expenses for nursing facility care are reduced at the state rate for nursing facility care that is owed by the client prior to Medicaid eligibility. It is based on the state rate for the particular facility the bill was incurred.
 - Medical expenses incurred more than three months before the month of application is not an allocable medical deduction to reduce participation.

Note: If an expense was used to meet a prior spenddown or to reduce excess resources for LTC programs, it cannot be used to reduce participation. This is the same rule as the spenddown program. An expense is allowed once.

Expenses of a medically necessary service animal

A description of service animals is described in WAC [388-473-0040](#) food for service animals as an ongoing additional requirements. Although this section describes when to authorize food for services animals of an SSI or TANF recipient, it can also be used as a guideline when determining if expenses related to a service animal can be used as a medical expense.

In order for expenses related to a service animal to be used as a medical expense:

Consult CARE and the client's social service specialist/case manager as to whether the service animal is medically necessary. If the social service specialist is unable to determine if the service animal is medically necessary get a

statement by the client's physician/practitioner as to why the expense is medically necessary.

The service animal must be performing a task that is necessary for the health and safety of the individual.

For LTC recipients with service animals that are on SSI, consider food for service animals as an [ongoing additional requirement](#). If authorized, do not allow the food as a medical expense to reduce participation.

Medical expenses and room and board

Noncovered necessary medical expenses is an allowable deduction to determine the client's participation. For HCBSS Waiver clients residing in alternate living facilities, it is not an allowable deduction from room and board without an exception to rule (ETR).

Submit an ETR request to the HCS regional designee for a medical expenses that would have been used to reduce participation if there had been available participation.

Room and board for ABD cash recipients is not reduced by medical expenses. Do not refer ABD cash cases for an ETR.

Reducing room and board is the last resort as it is state funded. If the expense can be deducted through participation, but takes a few months because of low participation, use that method rather than an ETR to reduce room and board.

Medicare supplements, called MEDI-GAP are not an allowable ETR from room and board if the client is eligible for a Medicare Savings Program (MSP), this is because MSP covers the same thing as a MEDI-GAP plan. For more information see [What about Medicare Insurance Supplements, also called MEDI-GAP plans.](#) (scroll down to this section).

See: [HCS Waivers, Room and Board, ETRs and Bed holds.](#)

DDA Waiver has a process to reduce room and board for necessary medical expenses and guardianship fees. DDA has authorized the case manager as the designee to approve these costs from room and board. DDA case-managers notify the financial worker via the DSHS 15-345.

Any deduction from room and board must be coded as an ETR in ACES 3G in the decision tree under the Institutional Care/Expenses.

TPL, COB, Premium Assistance program

[Medical Assistance-Third party liability](#)

[Long-term care and Third Party Resources, LTC Insurance](#)

When to allow medical expenses

Changes including medical expenses must be reported within the timeframes outlined in WAC [182-504-0110](#). WAC [182-504-0105](#)

Effective 10/2013 WAC [182-504-0105](#) Washington Apple Health - Changes that must be reported will be used for all medical including institutional medical programs.

If a medical expense is not reported within required time frames, we are not able to use the expense as a post eligibility deduction for institutional ~~in~~ Medicaid. For HCBS Waiver, we may allow a medical expense if unpaid as long it meets the criteria in WAC [182-513-1350](#) (6) and (7).

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If a medical expense increases and is not reported within time frames, we can't go back historically and change the amount. If a medical expense ends, (such as a health insurance premium), and it is not reported timely, it is an overpayment.

In order to allow a medically necessary non covered item, we will need verification:

- Of the cost
- Item is prescribed by an allowable practitioner and is considered a medically necessary item
- Item is not covered by Medicare, Medicaid or WAH managed care. Most medically necessary items should be covered for individuals receiving long-term care. Any item indicated on the [covered list](#), including [over the counter items](#) such as cough/cold medications or vitamins cannot be allowed as a participation deduction.
- For [durable medical equipment \(DME\)](#) or environmental modifications, check with the social worker/case manager as to whether it should be covered under the HCBS Waiver? Most DME is covered under the Medicaid scope of care or HCBS Waiver. HCS MB H13-030 dated June 24, 2013 has more information regarding DME vendors.

If the reported expense appears to be covered, send a letter explaining why the expense is not allowed using the text templates that include the rule.

Send the medical expense fact sheet to all new openings and clients that turn in expenses that are not allowed as a participation reduction.

Noncovered allowable medical expenses. Differences in how we apply the medical deduction in institutional medical and HCBS Waiver

Once it is determined the medically necessary expense is allowed as a deduction, there is differences in institutional and HCBS Waiver cases on when we allow the medical deduction.

Post eligibility participation (WAC [182-513-1380](#), WAC [182-515-1509](#), WAC [182-515-1514](#))

There are 3 methods of allowing expenses in post eligibility described in WAC [182-504-0120](#) (11) for institutional programs and WAC [182-504-0120](#) (12) for HCB Waivers.

Federal guidance allows method 1 or 2 for institutional cases. (Those residing in medical institutions).

Federal option allows method 3 for HCBS Waivers.

1. Method 1: Allow the expense in the month it was incurred; or

2. Method 2: Estimate medical expense incurred in the preceding period, not to exceed 6 months if the expenses are expected to continue. (Method 2)

- a. At the end of the prospective period, or if there is a significant change of 25%, the expense is reconciled for the next time period.
- b. A reconciliation is required, at least every 6 months when using method 2. Use barcode ticklers to track the expenses and reconciliation period.
- c. Use the Method 2 training instructions and calculator and document that method 2 is being used to estimate medical expenses.

3. Method 3: When there is a change in income, or allowable expenses, changes the amount of the cost of your care for a home and community-based waiver or service, we calculate the new participation amount effective the first of the month following the date the change was reported, except that the new

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participation amount will be effective the month the change occurs if the change is the loss of an income source that you report within thirty days of the change.

For additional information on Method 1, Method 2 and Method 3 go to the financial SharePoint site, financial training under the policy and program changes. HCB Waiver-Method 3

What if a Provider appears to be charging a client extra?

If a Medicaid or Medicare/Medicaid client is turning in medical expense charges that appear to be covered or the client is being charged the difference between the ~~the~~ Medicaid or ~~the~~ Medicare rate, you may need to refer the situation for an investigation.

- Nursing facility, Assistance Living, Group Homes or Adult Family homes contact: Residential Care Services (RCS) complaint email box Complaint Resolution Unit (DSHS/RCS) cru@dshs.wa.gov
- All other Medicaid providers [contact the Health Care Authority](#). Include your name, phone number, client and provider information and what the issue is.
- Refer complaints regarding Medicare claims to 1-800-Medicare
- If provider fraud is suspected, follow the procedures in HCS MB H13-011 issued 3/5/2013: procedures for report suspected fraud.

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Example:

~~Both Spouse's are at home receiving COPEs. Spouse #2 has an insurance premium and income over the PNA. Spouse #1 has no insurance premium, income over the PNA. Allow a portion of the insurance premium as a deduction for spouse #2 and the remainder of the premium as a deduction for Spouse #1~~

Example #1	-
Spouse #1	Spouse #2
Copes HCBS Waivers at home	Copes HCBS Waivers at home
Income \$1400	Income \$1000
-	Insurance Premium \$150
Allow deduction from the premium to bring Spouse #2 to the current PNA. Allow the remainder of Insurance Premium to Spouse #1	
Code at the LTCX	Code at the LTCX Screen

~~Set Tickler for COLA and premium adjustments~~

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Example:

~~Both spouse's are home receiving COPES HCBS waivers. Spouse #2 has an insurance policy premium and has income below the PNA. Spouse #1 has income over the PNA, no insurance premium. Allow the insurance premium from spouse #2 to spouse #1 as a deduction.~~

Example #2	-
Spouse #1	Spouse #2
Copes HCBS Waivers at home	Copes HCBS Waivers at home
Income \$1400	Income \$950
-	Insurance Premium \$100
Allow insurance premium of \$100 from Spouse #2 to reduce participation for Spouse #1	
Code at the LTCX for Spouse #1	-

~~Set tickler for yearly COLA and insurance adjustments~~

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Practitioners

Allowable practitioners	
MD physicians	Opticians
DO Osteopath	Pharmacists
DDS Dentists, Denturist, Orthodontist, Periodontitis	ARNP Advanced Registered Nurse Practitioners
DC Chiropractors	Psychologists/Psychiatrists
PA Physicians Assistants	CRN Certified Registered Nurses
DPM Podiatrists	Midwives
OD Optometrist	X-ray Technicians
Dental Hygienists	Electrotherapist
Hydro therapist	Inhalation/Respiratory Therapists
Physical Therapists	Speech Therapists
Allowable practitioners with a documented referral from an M.D., D.O., D.D.S., OR A.R.N.P.	
Acupuncturist	Dieticians

Naturopaths	Licensed Massage Therapist
Non Allowable Practitioners	
Herbalists	Homeopaths
Holistic Healers	Hypnotists
Masseurs or manipulators	Psychic or faith healers
Sanipractors	Veterinarians (unless the expense is for a medically necessary service animal)
Practitioners not licensed under WA State Law	Medical Marijuana Distributor

Nonallowable expenses, services and supplies

Nonallowable expenses, services and supplies	
Services obtained out of the US	Drugs not approved by the Federal Drug Administration (FDA)
Interest and fees incurred on an unpaid medical bill	Out of state billings for medical services not recognized under Washington State law.
Durable medical equipment or modification approved under the HCBS Waiver program for individuals receiving Waiver	Items covered under Medicare, Medicaid or a Healthy Options plan is not an allowable deduction from long-term care participation. If a client chooses to go to a non m Medicaid/ m Medicare contracted provider

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<p>services is not an allowable participation deduction</p>	<p>or outside the healthy options managed care network, the cost is their responsibility.</p>
<p>Insurance premiums for policies that pay a cash benefit to the insured and the benefit is not intended to reimburse a provider.</p> <p>These premiums are not health insurance but pay directly to the insurance holder under certain conditions. (usually a daily rate when the client is unable to work, in the hospital or has a certain type of medical condition).</p> <p>Contact the carrier to find out if it is a health insurance or one of these policies that pay a cash benefit to the client and not a provider because of a health condition.</p> <p>This does not include LTC insurance. LTC insurance premiums are an allowable deduction.</p> <p>LTC insurance policies waive the premiums when the client starts receiving benefits from the LTC insurance. Once the client is accessing LTC insurance, remove the premium as a deduction.</p>	<ul style="list-style-type: none"> • Food/special diets is not a medical expense • Nutritional supplements unless prescribed as medically necessary. Examples are enteral liquid and powdered supplements. • For active Medicaid clients, liquid supplements that are medically necessary are covered by Health Care Authority (HCA) Liquid supplements (enteral supplements) not approved by HCA are not considered a medically necessary expense to be used to reduce participation. • Food items are covered under the basic food program, consider eligibility for basic food for individuals not in a facility claiming food items as a medical expense. AFH, Assisted living facilities, NF and RHCs are required to provide meals taking into account an individuals special dietary needs. Meals are included in the daily rate.
<p>In home cooking/cleaning services/yard work/property maintenance</p>	<p>Over the counter drugs & medications not prescribed or considered not medically necessary. Many over the counter drugs, medications and vitamins are covered by Medicaid.</p>
<p>Telephone charges including long-distance charges</p>	<p>Health camps, trips or retreats</p>

Commercial diet clinics, gyms and pools that are not monitored by a licensed physical therapist	Medical marijuana. Cannabis is not an approved prescription drug under the Federal Food, Drug and Cosmetic Act and has not been approved by the FDA for treatment
Toiletries such as toothpaste, shampoo, personal grooming products	Unpaid participation incurred while active on a Medicaid program
Private alternate living facility (ALF) charges are not considered a medical expense.	Dietetics
See WAC 182-513-1205 for possible eligibility of Medicaid using rules for individuals living in state contracted ALFs.	Spouse's unpaid medical expenses are not allowed to reduce participation.

Note: LTC medical expenses are indicated on the LTCX screen. The MEDX screen is used for recipients on other programs such as food assistance. Non ~~m~~Medicare health insurance premiums are indicated on the MEDX screen for non institutional spenddown cases. Make sure the medical expense is indicated on the LTCX and MEDX screen when a LTC recipient is on food assistance.

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ACES and Medical Expenses

Institutional Care in ACES 3G decision tree used in institutional ~~m~~Medicaid programs to indicate medical expenses.

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Expenses in ACES 3G decision tree used to indicate health insurance premiums for spenddown. Used to indicate all medical expenses for food assistance including ~~COPES~~ [HCBS Waivers](#) participation.

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ACES on-line summary and detail used to indicate medical expenses for spenddown.

[ACES-LTC](#)

[ACES-Medical expenses as a deduction](#)

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