

Cathy Cooper

Authorized Signature

Number: SPD-PT-06-040
Issue Date: 10/6/2006

Topic: Other

Transmitting (check the box that best applies):

- New Policy
 Policy Change
 Policy Clarification
 Executive Letter
 Administrative Rule
 Manual Update
 Other: _____

Applies to (check all that apply):

- All DHS employees
 County Mental Health Directors
 Area Agencies on Aging
 Health Services
 Children, Adults and Families
 Seniors and People with Disabilities
 County DD Program Managers
 Other (please specify):

Policy/Rule Title:	MMA Policy Clarification: Medicare Part D Institutionalized Status Indicator		
Policy/Rule Number(s):		Release No:	
Effective Date:	10/1/2006	Expiration:	
References:			
Web Address:			

Discussion/Interpretation: As part of the Medicare Modernization Act project, DHS created 3 case descriptors to be used on UCMS/Oregon ACCESS cases. The codes are used to help determine client copayments for Medicare Part D covered medications. This information, along with other information, is transferred to the Centers for Medicare & Medicaid Services (CMS) each month to assure that clients are paying the correct co-pay amount under the Medicare Part D program. This data is sent to Medicare approximately 7 days before the end of each calendar month.

There has been some confusion regarding when it is appropriate to code the case with the ISI code. The Institutionalized Status Indicator (ISI) code tells Medicare and the Medicare Part D plans that a client is institutionalized, thus eligible for \$0 copayments for Medicare Part D covered drugs. Because of the many data transfers that have to occur before, there have been delays in clients' accurate payments when transitioning

to a nursing facility throughout 2006. The Centers for Medicare & Medicaid Services has recently provided guidance to the states that should help with this transition for clients. Medicare has clarified that prospective determinations of the Institutionalized Status is an acceptable practice to assure that clients are receiving the proper \$0 copayment as soon as eligible.

Qualification for the zero copayment is effective on the 1st day of the month in which a beneficiary is expected to remain in a *MMA qualified* long-term care facility for a full calendar month that is covered by Medicaid.

Local/Branch Action Required:

Please use the ISI case descriptor in the following manner:

Place the ISI case descriptor on Medicare client UCMS/Oregon ACCESS cases as soon as it is **reasonably expected** that a client will be in a Nursing Facility, a medical institution (hospital), psychiatric hospital, or an ICF/MR for a full calendar month.

The coding should not be removed until the client is out of the afore-mentioned facilities. If the coding is not placed on the client's case prior to the monthly transfer to Medicare, then the client will have a delay in receiving the \$0 copayment status.

Please continue to use the FS1 and FS2 coding for all clients that are not institutionalized:

FS1 Full Subsidy Individuals - either dual eligible (OHP plus & Medicare) or Medicare only eligible clients whose income is equal to or less than 100% FPL.

FS2 Full Subsidy Individuals - either dual eligible or Medicare only eligible clients whose income is greater than 100% FPL.

Central Office Action Required:

Field/Stakeholder review: Yes No

If yes, reviewed by: SPD Policy Team

Filing Instructions:

If you have any questions about this policy, contact:

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