THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS
Rule Number:	MSB 11-02-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-02-01-A, 8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.580.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Please remove current text from §8.580.3.F. through §8.520.3.F.5. All other text is for references purposes only.This change is effective July 1, 2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS
Rule Number:	MSB 11-02-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule requires nursing facilities to provide the following information to oxygen providers: the name and Medicaid ID number for clients using oxygen and related equipment; information on third party payers; a statement guaranteeing that oxygen will be used only by the clients named; and oxygen usage by client, in liters. There is no way to verify or use this information, and it is not necessary for nursing facilities to give this information to oxygen providers because the Department already has the information it needs to ensure that oxygen is used and reimbursed appropriately.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or

☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 CFR 440.70 (Home health services)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2010);
25.5-5-102, Section (1)(f), C.R.S.

Initial Review	**04/08/2011**	Final Adoption	**05/13/2011**
Proposed Effective Date	**07/01/2011**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS
Rule Number:	MSB 11-02-01-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Nursing facilities.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The rule change will reduce the administrative burden on nursing facilities. It has no impact on the Department's ability to regulate and manage client utilization of oxygen in the nursing facility.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs associated with this change because it eliminates a requirement and the administrative burden associated with it.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no costs for the proposed rule change. The Department no longer requires the information described in the rule to be collected, so the rule is obsolete.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department is already using other established systems to collect the necessary information. Therefore, less costly and intrusive methods have already been adopted.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Not applicable - this deletes rather than adds a part of a rule.

8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS

8.580.3.A. Oxygen, oxygen equipment and/or supplies when medically necessary and prescribed by the physician for clients residing in an intermediary or skilled nursing facility are a benefit.

8.580.3.B. Oxygen equipment and/or supplies for clients residing in a nursing facility being reimbursed a per diem amount, shall be provided by the nursing facility, except when the facility orders oxygen equipment and/or supplies specifically for the unique needs of an individual client. In such cases, the oxygen equipment and/or supply provider shall bill the Department directly.

8.580.3.C. Oxygen concentrators for use by clients residing in a nursing facility being reimbursed a per diem rate shall be provided in one of the following ways:

1. Oxygen concentrators purchased by the facilities shall be included in the facility cost report and reimbursed through the per diem. All necessary oxygen-related supplies shall be provided by the facility in accordance with 10 C.C.R. 2505-10, Section 8.441.5.K.

2. Clients residing in facilities that do not purchase oxygen concentrators shall obtain equipment and supplies from an authorized Medicaid oxygen provider. The oxygen provider shall provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's physician, and shall bill on the state approved form.

8.580.3.D. The oxygen provider shall bill the Department directly for medically necessary liquid or gaseous oxygen provided to clients residing in intermediary or skilled nursing facilities that are reimbursed a per diem amount.

8.580.3.E. The oxygen provider shall bill based on the information provided by the nursing facility. Claims shall be coded appropriately as defined by the Department. Reimbursement shall be the lower of the provider's billed charges or the Department's fee schedule.

~~8.580.3.F. The nursing facility shall provide the following information to the oxygen provider within 20 days following the date the provider delivers the equipment and supplies to the facility.~~

~~1. The name and state identification number for all clients provided liquid or gaseous oxygen, or the equipment and supplies needed for its administration.~~

~~2. Evidence that Medicare Part A or Part B or other third party resources are available or unavailable.~~

~~3. The name and state identification number for all clients utilizing an oxygen concentrator, rented from the oxygen supplier, who reside in a facility not providing facility-owned concentrators.~~

~~4. A statement guaranteeing that equipment, supplies, and oxygen were used only by the client for whom they were supplied.~~

~~5. In the case of a facility utilizing centralized oxygen systems, specific client oxygen usage, expressed in liters.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	School Health Services
Rule Number:	MSB 11-02-04-A
Division / Contact / Phone:	Financial and Administrative Services Office / Nancy Dolson / 303 866 3698

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-02-04-A, School Health Services
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.290.6.D, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.290.6.D through §8.290.6.D.6 with new text provided from §8.290.6.D through §8.290.6.D.8. All other text included is for reference purposes only. This change is effective 07/01/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	School Health Services
Rule Number:	MSB 11-02-04-A
Division / Contact / Phone:	Financial and Administrative Services Office / Nancy Dolson / 303 866 3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Revisions to citations in the School Health Services Rule are necessary to clarify the requirements for Medicaid claims submissions and identify changes to the interim payment process for participating school districts or Board of Cooperative Education Services (BOCES) that provide school health services. The proposed interim payment process is being revised so that each district's cash flow can be more predictable on a monthly basis and more in line with the district's actual allowable costs at the time of cost settlement. The proposed citations shall provide specific and clear guidance so that participating providers can administer the School Health Services Program according to federal mandates and appropriately seek interim payment for those services. The rules are necessary for the proper and efficient administration of the School Health Services Program.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-5-318, C.R.S. (2010)

Initial Review	**04/08/2011**	Final Adoption	**05/13/2011**
Proposed Effective Date	**07/01/2011**	Emergency Adoption	

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	School Health Services
Rule Number:	MSB 11-02-04-A
Division / Contact / Phone:	Financial and Administrative Services Office / Nancy Dolson / 303 866 3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Participating school districts and Board of Cooperative Education Services (BOCES) who participate in the School Health Services Program will be impacted by the proposed rules. The revised citations shall clarify that participating school districts or BOCES must follow claims submission requirements to seek interim payment for providing school health services and that interim payment will be reimbursed on a monthly rate based on each provider's actual allowable costs as identified in the provider's most recently filed cost report. The revised citations provide specific and clear guidance so that participating school districts and BOCES can administer the program according to federal mandates and appropriately seek interim payment for services provided.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   There is no expected change in annual aggregate expenditures to school districts and BOCES participating in the School Health Services Program.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no additional costs to the Department to administer the interim payment process for the School Health Services (SHS) Program through a monthly rate rather than the procedure code specific fee-for-service rates. The proposed monthly rate will reduce overpayments made to participating school districts or BOCES and allow the providers to budget more effectively. Additionally, it will reduce administrative burden on the providers and Department because interim payments will more accurately reflect the provider's actual allowable costs. Thus, during the annual cost reconciliation and settlement there will be less districts in a payback situation and less effort around that type of activity.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

There is no expected change in the annual aggregate expenditures. Interim payments reimbursed on a monthly rate will be based on each provider's actual allowable costs as identified in the provider's most recently filed cost report and shall allow each provider to budget more effectively.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department is unable to find less costly or less intrusive methods to reimburse for school health services as mandates set forth by the Centers for Medicare and Medicaid Services (CMS) require claims submissions, interim payments, an annual cost report and cost reconciliation/settlement process. Reimbursing providers through interim payments on a monthly rate based on each provider’s actual allowable costs as identified in the provider’s most recently filed cost report is less costly or intrusive then reimbursing providers on manually priced procedure code specific fee-for-service rates and shall minimize provider's overpayment during the interim payment process.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Presently, providers are reimbursed interim payments through manually priced procedure code specific fee-for-service rates. Throughout the state fiscal year, rates are adjusted to try to align interim payments more closely to the provider's actual costs identified in the provider's most recently filed cost report. Even with rate adjustments, providers have been overpaid resulting in a payback situation during the annual cost reconciliation/settlement. Through research, the proposed method is the only alternative where the Department can provide a provider specific rate during the interim payment process so that each provider's cash flow can be more predictable on a monthly basis and more in line with the provider's actual allowable costs at the time of cost settlement.

8.290.6 REIMBURSEMENT

8.290.6.A. The Participating District shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.

8.290.6.B. The Participating District shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.

8.290.6.C. The Participating District shall participate in a periodic time study based on instructions documented in the Department's School Health Services Program Manual, to determine the percentage of allowable time spent providing Medicaid-claimable School Health Services.

8.290.6.D. Claims Submission and Interim Payment

1. The Participating District shall submit a procedure code specific fee-for-service claim for each School Health Service~~benefit service~~ provided for each client.~~, based on rates established by the Department.~~

~~2. Rates shall be paid on a fee-for-service basis and shall serve as an interim payment for School Health Services provided.~~

2~~3~~. Interim payment for School Health Services provided shall be reimbursed on a monthly rate. The monthly rate shall be based on the Participating Districts actual, certified costs identified in the Participating Districts most recently filed annual cost report. For a new Participating District, the monthly rate shall be calculated based on historical data.

3. Interim payment shall be tied to claims submission by the Participating District. Claims shall be monitored by the Department and if claim volume decreases significantly or drops to zero in any two consecutive months while school is in session, interim payment shall be withheld until the issue has been resolved.

4. The Participating District shall be notified of the monthly rate each state fiscal year no later than 30 days prior to July 1 of that state fiscal year.

5. The Participating District shall receive the federal share of the rate, not to exceed 100% of the federal match rate, as interim payment.

6~~4~~. School Health Services provided shall be billed as an encounter or in 15-minute unit increments, in accordance with proper billing practices as defined by the Health Insurance Portability and Accountability Act or by the Healthcare Common Procedure Coding System.

7~~5~~. Specialized Transportation services shall be billed as one-way trips to and from the destination.

8~~6~~. Each Participating District submitting claims for reimbursement shall follow proper billing instructions as outlined in the Department's School Health Services Program Manual and in accordance with 10 C.C.R. 2505-10, Section 8.040 and 8.043.

8.290.6.E. Cost Reconciliation and Final Payment

1. Each Participating District shall complete an annual cost report for School Health Services delivered during the previous state fiscal year covering July 1 through June 30. The Cost Report shall:

a. Document the Participating District's total Medicaid allowable scope of costs for delivering School Health Services, based on an approved cost allocation methodology; and

b. Reconcile the interim payments made to the Participating District to the Medicaid allowable scope of costs, based on an approved cost allocation methodology.

2. Each Participating District shall complete and submit to the Department a cost report on or before October 1 of the fiscal year following the end of the reporting period.

3. All annual cost reports shall be subject to an audit by the Department or its designee.

4. If a Participating District's interim payments exceed the actual, certified costs of providing School Health Services, the Participating District shall return an amount equal to the overpayment.

5. If a Participating District's actual, certified cost of providing School Health Services exceeds the interim payments, the Department will pay the federal share of the difference to the Participating District.

6. Each Participating District shall follow cost-reporting procedures detailed in the Department's School Health Services Program Manual.

8.290.6.F. Certification of Funds

1. The Participating District shall complete a certification of funds statement, included in the cost report, certifying the Participating District's actual, incurred costs and expenditures for providing School Health Services.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Verifications §8.100.4.B. & 8.100.5.B.
Rule Number:	MSB 11-03-14-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-03-14-A, Revision to the Medical Assistance Rule Concerning Medicaid Verifications §8.100.4.B. & 8.100.5.B.
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.4.B. & 8.100.5.B., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided at §8.100.4.B.2.c (par 2).
Please replace current text at §8.100.5.B.1.c (par 2) with new text provided. Please insert new text provided at §8.100.5.B.1.h and §8.100.5.B.1.i. All other text is provided for reference purposes only. This change is effective 07/01/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Verifications §8.100.4.B. & 8.100.5.B.
Rule Number:	MSB 11-03-14-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The proposed language clarifies and makes consistent language authorizing telephone calls to employers. This rule allows applicants the option to request that communication with their employers be made in writing as opposed to a telephone call to the employer.

Current eligibility processes call for an initial request that the applicant supply documentation from their employer. This allows the applicant the opportunity supply the requested documentation while maintaining their confidentiality. If additional information is needed directly from the employer, the applicant should have the opportunity to be aware of the extent that the eligbility site is communicating with their employer. Applicants may choose to require that this communication be done in writing. Contacting applicant's employers should be limited to when submitted information is considered questionable as outlined in 8.100.4.B.3 or as outlined in other rules.

This rule also adds language to Section 8.100.5.B. regarding eligibility site practices regarding questionable verifications from applicants.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   §25.5-1-201, §25.5-1-303,
   and §25.5-4-104, C.R.S.

Initial Review	**04/08/2011**	Final Adoption	**05/13/2011**
Proposed Effective Date	**07/01/2011**	Emergency Adoption	

DOCUMENT # 03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Verifications §8.100.4.B. & 8.100.5.B.
Rule Number:	MSB 11-03-14-A
Division / Contact / Phone:	CCR / Ann Clemens / 6115

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The class of persons that will be affected and benefit from this proposed rule change are Medicaid program clients with work income.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The population affected by this change will have the option of how eligibility site staff communicate with their employers. Applicants may not want eligibility site staff to communicate with their employers by telephone. The proposed language would allow the applicant to request that any communications with their employers be made in writing to assure that the applicant is aware of the extent of communications with their employers.

Applicants should have the opportunity to submit wage documentation directly from their employer before an eligibility site contacts the employer in order to give the applicant the opportunity to maintain their confidentiality. Contacting applicant's employers should be limited to when submitted information is considered questionable as outlined in 8.100.4.B.3. or as outlined in other rules.

This rule also adds language to Section 8.100.5.B. regarding eligibility site practices regarding questionable verifications from applicants. Additional verifications from outside sources should be limited to when submitted verifications are questionable. This should reduce administrative burden for eligibility sites and applicants as well as allowing applicants the opportunity to maintain their confidentiality.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There are no anticipated costs associated with this change.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

N/A

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

N/A

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The Department considered allowing eligibility sites to contact employers without regard to the applicant's request. This was rejected in favor of allowing applicant's the right to chose how eligibility site staff communicate with their employers.

8.100.4.B. Family and Children's Minimal Verification Requirements

1. The particular circumstances of a family will dictate the appropriate documentation needed for a complete application. Documentation to establish that a situational requirement is met is needed only when inadequate or inconsistent information supplied by the caretaker relative warrants securing verification to clarify a question of eligibility.

2. Minimal Verification - The following items shall be verified for all families applying for medical assistance:

   a. A Social Security Number shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

   b. Verification of citizenship and identity as outlined in section 8.100.3 under Citizenship and Identity Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      If the applicant is self employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

      Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

   d. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

   e. Pregnancy verification, if applicable, and if the pregnancy is not observable. The verification shall be documented according to 8.100.4.G.9.a.

   f. Unearned income may be declared by the client verbally or in writing on the application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

   a. A Social Security Number shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

   b. Verification of citizenship and identity as outlined in the section 8.100.3 under Citizenship and Identity Eligibility Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      If the applicant is self employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer~~, if the applicant authorizes the telephone call~~. Applicants may request that communication with their employers be made in writing.

      As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

   d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

   e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

f. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

g. Pregnancy verification, if applicable, and if the pregnancy is not observable. The verification shall be documented according to 8.100.4.G.9.a.

h. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

i. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.