Indiana Health Coverage Program Policy Manual
Chapter 4600 BENEFIT RECOVERY Sections 4600.00.00 – 4650.20.05

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4600.00.00 BENEFIT RECOVERY

This chapter presents policies and procedures on the following topics:

- Identifying Over Issuances (Section 4605)
- Types of Over Issuances (Section 4610)
- Over Issuance Calculation (Section 4620)
- Initiating Collection Action (Section 4630)
- Recovery Methods (Section 4635)
- Transmittal of Repayment (Section 4640)
- Claim Against Estate (Section 4650).

4605.00.00 IDENTIFYING OVER ISSUANCES

An over issuance exists when an AG received benefits when it was not eligible to receive benefits, or in the case of spend down or liability, when the AG received benefits in an amount greater than it was eligible to receive. Benefit Recovery will not be pursued if the correct information would only have affected the amount of monthly premiums or POWER Account contributions.

Benefit Recovery will be pursued for assistance groups where the member failed to report or falsified information which would have made them completely ineligible for the assistance they received. This means that income reporting would not affect categories such as MA X, MAGP, MASI, MAMA, MA 4, MA 8, MA 15, and MA Q.

The claims process begins with the identification of an over issuance. This occurs when the eligibility worker receives or discovers information which appears to contradict information previously used to determine eligibility. The worker may receive information that an over issuance has occurred because of any of the following scenarios:

- An untimely reported change
- Information from individuals inside/outside the AG
- Fair hearing decision found unfavorable to client
- Transfer penalties
- Quality Control (QC) referral
- Management Evaluation (ME) review
- Office of Inspector General (OIG) investigation/audit report (referred through Central Office)
- Central Office referral.

The source reporting information may have already conducted a case review and obtained documentation to resolve the discrepancy and determine the time and amount of any over issuance.

The eligibility worker may also discover information contrary to what is in the case record from review of reports from one of the following sources:

- Department of Workforce Development (through data exchange)
- Social Security Administration (SSA) (through data exchange)
- Internal Revenue Service (IRS) (through data exchange)
- Bureau of Motor Vehicles (BMV)
- Financial institutions.

4605.05.00 STAFF RECOVERY RESPONSIBILITIES

Recovery responsibilities of the eligibility worker and supervisor, the Benefit Recovery worker and Benefit Recovery supervisor and the Fraud Referral Coordinator are provided in the following sections.

4605.05.05 ELIGIBILITY WORKER RESPONSIBILITIES

When a possible over issuance is identified, the worker must gather and record the following information in running record comments:

- The cause of the over issuance
- How the over issuance was discovered
- The date the agency became aware of an over issuance
- Who received the income/resource/status change?
- The date the income or change started and/or stopped
- The estimated length of over issuance
- Any explanation given for failure to provide information accurately or in a timely manner
- Corrective action taken and the date such action was taken.

Before completing a referral to the Benefit Recovery unit, the worker must review the above information to determine what further information/verification is still needed and take the actions listed below.

- Obtain verification necessary to determine the period and the amount of over issuance
- Adjust the current benefit, if appropriate, prior to referral to Benefit Recovery
- Verify that the individual was receiving assistance, during the time the claim of over issuance was presumed
- Advise the AG in writing that a discrepancy exists, that the source of the discrepancy is from outside the AG and that a referral to Benefit Recovery will be made regarding the overpayment if the discrepancy cannot be resolved.

If the over issuance is referred to the prosecutor, do not discuss the possibility of repayment with any member of the AG before the final court disposition.

The AG will be allowed 10 days to rebut the allegation prior to referral to Benefit Recovery. The eligibility worker must allow the AG an opportunity to provide information which clarifies the situation. The eligibility worker must also:

- Complete the Overpayment Details- Referral Details page Benefit Recovery within 30 calendar days of the day the agency became aware of the overpayment (refer to Section 4620.00.00, completing the Benefit Recovery Referral).
- Respond to the Benefit Recovery unit requests for any additional information within 10 calendars days.
- If notified that a payment has been received and no referral exists, determine if over issuance occurred and enter information on the Overpayment Details- Referral Details page.
- If notified that a payment has been received and no over issuance exists, the payment must be returned to the individual.
- When notified that attendance is required, prepare for appearance in court or at a hearing.

4605.05.10 BENEFIT RECOVERY WORKER RESPONSIBILITIES

The Benefit Recovery caseworker is responsible for the establishment of all over issuance claims and the maintenance of recovery activities except the receipt of any repayments.

4605.05.15 FRAUD REFERRAL COORDINATOR/BENEFIT RECOVERY CODY USER RESPONSIBILITIES

Certain Benefit Recovery workers also serve as the contact for all fraud, investigation, and referral activity.

The responsibilities of the Fraud Referral Coordinator/Benefit Recovery CODY user are:

- Review all claims purported to be fraud before they can be opened. Decide on further action.
- Monitor all fraud referral and investigation activities conducted within DFR.
- Serve as contact for Central Office staff on matters related to claims, collections, adjudications, and investigations.
- Maintain all fraud activity records including Fraud Hotline Referrals, other program abuse complaints, referrals for investigations, prosecutions, and criminal court results. Assign CODY investigation numbers to all referrals to be investigated by Benefit Recovery or Compliance Division.

- Review all referrals for investigation. When appropriate, make a referral to the Compliance Division.
- Review all completed investigations to determine the appropriate action to be taken on the case.
- Whenever possible, seek adjudication. Review resulting claims and enter in CODY along with adjudication results.

4610.00.00 TYPES OF OVER ISSUANCES

Once an over issuance is identified, the reason for the over issuance must be identified.
An over issuance may be the result of:

- Client error
- Intentional program violation (fraud); or
- Combination of the above.

A Medicaid claim cannot be adjudicated as IPV in an Administrative Disqualification Hearing, and even if a Medicaid claim is part of a Prosecution case found guilty, it must be entered in IEDSS as 'CE'. n 4610.10.00.) Benefit Recovery will not be pursued for agency errors which resulted from worker error. These types of errors are accounted for through Medicaid Quality Control and PERM review processes.

The only exception to this is when a transfer of property penalty was not applied or was not applied timely. See IHCPPM 4650.00.00 for more information.

4610.05.00 AGENCY ERROR DEFINITION

An Agency Error (AE) is an action or failure to act by the Division of Family Resources.
Examples of agency error may include:

- A misapplication of policy
- A calculation errors
- A computer processing error
- Failure to take prompt action on available information
- Some other error over which DFR has control.

4610.10.00 CLIENT ERROR DEFINITION

Client error is an over issuance caused by a misunderstanding or an unintended error on the part of the AG. Eligibility workers can help to eliminate this type of error by making sure the client understands what is needed and by what date. Eligibility workers can also help by being well organized, so that reported changes are always acted upon and never lost. A Medicaid error of this type is coded as client error. A client error can occur because of:

- AG failure to provide correct or complete information
- AG failure to report required changes in the AG's circumstances
- AG receipt of benefits (or more benefits than it was entitled to receive) pending a fair hearing decision.

4610.15.00 SUSPECTED FRAUD DEFINITION

Fraud is the act whereby a person willfully and deliberately makes false statements or suppresses facts or gives information which misrepresents the true circumstances regarding themselves or others for the purpose of receiving assistance to which there is not entitlement. Suspected fraud over issuances can occur because of the AG:

- Misrepresenting information
- Concealing information
- Withholding information pertinent to determining eligibility, including untimely reporting
- Failing to report a change to continue to receive benefits for which the AG was not entitled
- Intentionally altering or changing documents to obtain benefits to which the AG was not entitled.

Fraud, in all its aspects, is a matter of legal determination. Therefore, fraud does not exist until this legal determination has been made through the criminal court.

Once the suspected fraud claim has been calculated **but not yet opened**, the entire claim case will be submitted to the Bureau of Investigations for review and approval.

4610.15.10 DETERRENTS AGAINST FRAUDULENT ACTIVITY

The DFR is to establish deterrents against fraudulent activity through:

- Skilled investigation
- Careful explanation of all eligibility requirements to applicants/recipients
- Diligent use of collaterals and other sources of information
- Verification of facts
- Alertness to possible misunderstandings
- Follow-up investigations were indicated
- Establishment of procedures for handling cases of suspected fraud to ensure thorough investigation and proper referrals to the County Prosecutor.
- Cooperation with the news media in publicizing cases prosecuted for welfare fraud.

4610.15.15 ESTABLISHMENT AND INVESTIGATION OF POSSIBLE FRAUD

Documentation of the applicant's/recipient's apparent ability or inability to understand questions regarding eligibility, especially regarding income and resources, must be entered in the Benefit Recovery notes. It is unlikely that fraud can be established and substantiated if the documentation shows that the individual's mental or physical condition resulted in his inability to understand eligibility requirements and his responsibility to provide information to the DFR.
The eligibility worker may suspect fraud exists within an AG.

Some clues which may indicate unwarranted receipt of assistance are:

- Purchase of items which indicate that more income exists than is known
- Living at a higher standard than known income would permit
- Unexplained absences or difficulty in seeing the recipient to complete necessary redeterminations
- Reluctance to provide needed information about income and/or resources
- Unexplained and continued refusal to have certain pertinent references or relatives contacted
- Complaints or remarks of other persons.

The worker should be alert to any information that can lead to the identification of a case discrepancy. If such information becomes available, the worker should take the action listed in Section 4605.05.05, Caseworker Responsibilities, then enter a referral to the Benefit Recovery unit on the Overpayment Details- Referral Details page Benefit Recovery if appropriate.
The worker is responsible for completing all investigations that can be done from the office: By phone, mail, or interview. This includes data matches.

Use Subpoena (Form FI0018/State Form 48133) to obtain needed verification when a signed client "Release of Information" is not available or appropriate. If it appears that the investigation cannot be completed by the eligibility worker, a suspected fraud task can be created to the Benefit Recovery Unit who can make a referral to the Bureau of Investigation.

4610.15.20 INVESTIGATION OF POSSIBLE FRAUD

If the AG is currently eligible, assistance is not to be discontinued solely because an investigation of suspected fraud is being conducted, nor is the worker to discuss an investigation by the Bureau of Investigation with the client.

The DFR is required to pursue suspected fraud. It is the responsibility of the eligibility worker to do the initial investigation and then, if appropriate, create a suspected fraud task for Benefit Recovery. Based on the Benefit Recovery worker and the B of I investigator's findings, and if the case meets the Local Prosecutor's criteria, the individual may be referred for prosecution to the County Prosecutor.

The methods used in investigating possible fraud should be adapted to the situation of the AG and the eligibility factors concerned. The investigation must be conducted in such manner that:

- The legal rights of the AG are preserved
- The privacy of the home is not invaded without consent
- Search and seizure are not committed
- The AG's right to due process of law is protected
- The right to legal counsel is not obstructed
- Confidential information is used only for the administration of assistance.

4610.15.25 REPORT OF FRAUD INVESTIGATIONS AND ADJUDICATIONS

When the investigation is completed, a report of all facts in the case is to be made. If the report reveals no basis for the suspicion of fraudulent activity, such decision is to be entered in the case record. Exoneration of the innocent is as important as prosecution of the guilty. If the report indicates a basis for suspected fraud, the period during which it is believed that the AG fraudulently obtained assistance is to be made a part of the record.

It is important that **all** investigations for **all** programs be entered in CODY System. The Benefit Recovery worker's initial investigations should be entered as well as referrals to the Bureau of Investigation. Update and add information as changes occur.

All individuals referred for prosecution or an ADH must be reported in CODY. CODY must be updated as each case progresses through the legal system.

4610.15.30 REFERRAL TO COUNTY PROSECUTOR

The Bureau of Investigation will decide whether to refer a case for prosecution. The County Prosecutor has the final word concerning the type and number of cases against which criminal charges will be filed or whether criminal charges will be filed at all. The DFR should have an agreement with the Prosecutor and knowledge of the documents and procedures which the Prosecutor will request. All available evidence must be provided with the referral. Repayment of a claim must never be discussed with the AG pending the outcome of the Criminal Court action; therefore, claims intended for prosecution should not be opened until adjudication is completed.

Once the decision has been made to refer the claim(s) for prosecution, 'prosecutor information' must be entered in the Benefit Recovery notes.

A specific criminal statute exists for acts of welfare fraud committed September 1, 1984, or after and is applicable for all programs. There are five separate areas of welfare fraud and abuse listed.

The accused person must knowingly or intentionally:

- Obtain public relief (or assistance) by impersonation, false statement, or other means.
- Acquire, possess, use, transfer, sell, trade, issue or dispose of public relief or an authorization document used to obtain public relief.
- Use, transfer, acquire, issue, or possess a blank or incomplete authorization document to secure public relief.
- Counterfeit or alter an authorization document to receive public relief or use, transfer, acquire or possess a counterfeit or altered authorization document; or
- Conceal information for the purpose of receiving public relief or assistance.

4610.20.00 EVIDENCE USED TO SUBSTANTIATE FRAUD

When preparing a case for a court, evidence is necessary to prove the DFR's allegation of fraud. Evidence can include written records or statements or verbal testimony. Information received through Data Exchange is not verified unless the agency providing the information is the source of the payment. It is necessary to secure verification directly from the employer, bank, or other source of the income.

It is also necessary to prove the intent to fraud. Verification that the AG member understood his responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

- The completed Rights and Responsibilities form
- The signed application
- Previously submitted Change Report forms
- Recorded and/or verified instances of other changes reported by the AG which could or did affect the benefits received.

An application or Change Report form submitted during the period fraud is suspected which omits the information that resulted in the over issuance may be used to substantiate intent. Recorded instances which indicate that the AG visited/called the office during the period fraud is suspected and did not report the change which resulted in over issuance may be used to substantiate intent. These instances might include a record of the date's benefits were issued to the AG, redetermination interviews with applications, signed Notice of Rights and Responsibilities or Personal Responsibility Agreement, or reports of beneficial changes but not the adverse change.

These examples are not all inclusive; other types of evidence of intent may also be used.

4610.25.00 COURT DETERMINATION OF FRAUD

Fraud must be determined by a court of appropriate jurisdiction. This may be through criminal court. The court may designate a repayment schedule. This schedule may be in conjunction with probation. If this occurs the judge may order repayment be made through the County Court or

probation system. If the ordered restitution is less than the claim, unless the court order strictly forbids any further collection after the restitution is paid, the balance should be collected. Since June 1999, Small Claims Court can no longer be used to determine fraud, but it can be utilized to assist in collection efforts.

4620.00.00 COMPLETING THE BENEFIT RECOVERY REFERRAL

Once it has been determined that an over issuance referral is necessary and that the over issuance occurred within the appropriate time as listed in the previous section, the eligibility worker is to complete the Benefit Recovery Overpayment Details-Referral Details page. Refer to Section 4605.05.05, Eligibility worker Responsibility, as to the necessary information which must be entered in the Benefit Recovery Notes. If incorrect dates are entered, the Benefit Recovery worker can correct these dates later the Overpayment Details- Referral Details page

4620.05.00 ASSIGNING THE REFERRAL TO THE BENEFIT RECOVERY WORKER

After a Benefit Recovery referral has been made a task is generated for a Benefit Recovery worker. All claim referrals are to be assigned to a worker within ten working days of the referral being made.

4620.05.10 TOTAL INELIGIBILITY

Failure to meet certain eligibility requirements will render an AG totally ineligible, thus negating the necessity for individual monthly calculations. These eligibility factors include:

- State residency
- Excess resources
- Excess gross income
- Entire AG made up of individuals who fail to comply with SSN requirements
- AG's refusal to provide requested information/verification (use Form 2244) concerning AG composition, income, or resources.

4620.35.00 DETERMINING THE AMOUNT OF OVERPAYMENT (MED)

The total amount of Medicaid benefits paid during a period in which the AG was ineligible for MA is recoverable from the recipient or his estate.[1]

For a member who was covered in a managed care program, this would be the monthly capitation paid by the state for each ineligible month, not the paid claims.

For information regarding the filing of a claim against an estate, refer to Section 4700.00.00.

Recovery can be pursued even when there is no suspicion of fraud. Medicaid benefits paid in error pending receipt of a hearing decision are to be recovered.

A recipient who acquires excess resources is totally ineligible. The amount which is recoverable is the total Medicaid expenditures for the month in which the recipient was ineligible.

An overpayment of Medicaid benefits may occur because of budgeting an incorrect amount of income; however, consideration of the income may result in the imposition of or increase in liability rather than total ineligibility.

The calculation of the Medicaid overpayment is done off-line. This information is then entered into the system to proceed with the Benefit Recovery process.

For the individual, whose liability should have been higher, the amount to be recovered is the difference between the correct and incorrect liability or the amount of Medicaid expenditures for the month, whichever is less.

For the individual, whose liability should have been higher, the amount to be recovered is determined as follows:

1. Subtract the incorrect liability from the correct liability.
2. From that difference, subtract the individual's "out of pocket" expenses and his spouse's/parent(s)' out of pocket expenses incurred that have not already been entered into the system as non-claims.
3. The resulting amount or the amount of the Medicaid expenditures for the month, whichever is less, is the amount to be recovered.

When requesting the claim history of all Medicaid expenditures the DFR should use State Form 6533 OMPP 1042 (revised 7-03) and follow the procedures below:
For medical expenditures involving recipient Third Party Liability (TPL), requests should be addressed to:

IHCP Third Party Liability
PO Box 7262
Indianapolis, IN 46207-7262

Requests for Medicaid expenditures involving recipient fraud, estate recovery and all other Medicaid expenditure requests involving reimbursement should be addressed to the Office of Medicaid Policy and Planning (OMPP) Attn: Estate Recovery, 402 W. Washington, Room W-374 MS 07, Indianapolis, IN 46204 (EstateRecovery@fssa.in.gov).

Example 1:
The DFR verified that as of April the AG had $500 in excess resources, which had not been reported. As of May 1st, the AG's resources were within the resource limitation. Medicaid expenditures for April were verified to be $750. The amount to be recovered is $750.

Example 2:
Based on the AG's reported income, the member had a liability of $34. In March they began receiving rental income. This was discovered in July and a $100 increase in the liability was budgeted effective August 1st. Recovery is for the months of May through July.

Incorrect liability amount	$34
Correct liability amount	$134
Difference	$100

Month	Out of Pocket Expenses	Medical Expenditures
May	5/11 - $10 - wife 5/20 - 25 - recip.pd. $35	$150
June	6/10 - $40 - wife	$ 50
July	None	$200

For May:
$100 (difference between correct and incorrect liability)
- 35 (recipient's "out of pocket" expenses and his wife's expenses)
$ 65 (recovery amount because it is less than expenditures)

$150 Medicaid expenditures

For June:
$100 (difference between correct and incorrect liability)
- 40 (wife's expenses)
$ 60 (recovery amount)

$ 50 Medicaid expenditures; Recovery amount

For July:
$100 (difference between correct and incorrect liability)
The recovery amount is $100

The total recovery amount is $215.

Example 3:
Based on the AG's reported income, she had a liability of $1500. In July they began receiving monthly payments from an annuity. This was discovered in November and a $200 increase in

the liability was budgeted effective December. Recovery is for the months of September through November.

Incorrect liability amount	$1500
Correct liability amount	$1700
Difference	$200

For September: $200 (difference between correct and incorrect liability)
For October: $200 (difference between correct and incorrect liability)
For November: $200 (difference between correct and incorrect liability)

The total recovery amount is $600.

4630.00.00 INITIATING COLLECTION ACTION

Collection activity will begin when the Benefit Recovery worker changes the status code on the Benefit Recovery-Referral Details page to OA, Open Awaiting Client Response. This will generate the demand notice to the payee of the AG for repayment of the claim.

Claims against an AG with multiple claims will be collected in sequence.

4630.25.00 NOTIFICATION OF MEDICAID OVER ISSUANCE

After the Benefit Recovery referral has been investigated and established as a claim, code OA should be entered in the status field of Benefit Recovery the Benefit Recovery-Referral Details page to open the claim. When the code is entered the system automatically generates a notice of Medicaid over issuance. The notice lists the amount of the overpayment, available repayment methods and appeal

4635.00.00 RECOVERY METHODS

Recovery of amounts of over issuance will be made by one or more of the following methods:

- Lump sum and/or installment payments
- Interception of lottery winnings
- Federal pay and/or State tax refund interceptions
- A combination of the above.

The Benefit Recovery worker must notify the overpaid AG of the amount and cause of over issuance as well as the various repayment methods available.

4635.05.00 LUMP SUM AND INSTALLMENT PAYMENTS

AGs will be given the option of repaying an over issuance either in a lump sum or in regular installments. This includes former AGs who are under court order to repay if the order does not require repayment in a specific manner.

The Benefit Recovery unit will negotiate a payment schedule with the AG and accept regular installments for repayment of any amounts of the over issuance not repaid through a lump sum payment.

Any payment will be accepted and credited to the claim, but unless the repayment plan is acceptable, it will not prevent the claim from being delinquent. Payments are due by the 28th of each month. If the minimum acceptable payment is not made by that date, the claim is delinquent. If the client has both a TANF and/or a Medicaid and a SNAP overpayment and does not specify to which claim a repayment should be applied, the payment is to be divided equally between each program.

Minimum acceptable payments will repay any claim within three years. When the claim is paid in full, the system will automatically close the claim and send an alert to the worker.

4635.10.00 SOCIAL SECURITY BENEFITS

Medicaid Benefit Recovery cannot be made from active members of RSDI or SSI benefits provided by the Social Security Administration. The federal government is only allowed to pursue garnishment of benefits in the following situations:

- Payments for child support or alimony
- Payments for court-ordered victim restitution
- Levy for unpaid federal taxes.

4635.25.00 CIVIL ACTION

All steps necessary to institute civil action are taken when the Benefit Recovery unit determines that such action is required to recover over issuances from former AGs.

If a case is returned indicating that civil action cannot be taken against an AG, the Benefit Recovery unit will notify the referring caseworker that there is an unpaid over issuance which cannot be collected at this time.

4635.30.00 VOLUNTARY REPAYMENT/CIVIL RECOVERY

After determining that a Medicaid overpayment has occurred and repayment is appropriate, the DFR is to discuss with the AG the reason recovery is necessary and whether he will voluntarily make repayment. If the AG is willing to repay, he or she must sign a repayment agreement.

Cases are to be referred to Small Claims Court when AGs refuse to sign the repayment agreement or fail to make repayment within the specified period. The DFR must present to the judge all necessary evidence, including the legal basis, substantiating those benefits were paid incorrectly on behalf of the individual. Additionally, the DFR must present documentation showing potential sources from which recovery can be made.

Recovery cannot be made from SSI benefits provided by the Social Security Administration.[2] However, Small Claims Court can still issue a judgment if the AG has no available income or assets, or his MA case has been discontinued.

When the DFR receives a favorable judgment in a Small Claims Court, the judgment is to then be entered on the Circuit Court docket as a permanent court record since this is not done by a Small Claims Court. Through this recording an individual can be pursued on the judgment through a lien on real property.

The FSSA Office of General Counsel is to be consulted for specific information and/or assistance regarding Small Claims Court procedures and other legal matters which may arise when pursuing recovery.

4635.35.00 HEARING REQUESTED ON OVER ISSUANCE

When an AG requests a fair hearing regarding the circumstances of an over issuance, the amount of over issuance, or the repayment plan established by the Benefit Recovery unit, the Fair Hearing > Maintain Appeal page must be completed. When the individual's request is in writing, a copy must be sent to Hearings and Appeals, 402 West Washington Street, Room E034, Indianapolis, IN 46204. A copy may also be faxed to 317-232-4412.

When the hearing decision is issued, an alert will be generated so the worker is aware of the results. If the county is sustained, the worker will request a new notice be generated to the AG giving them another 30 days to sign a repayment agreement and make their first payment. If the county is not sustained, the claim will need to be terminated and any payments that had been collected will need to be refunded. The Administrative Law Judge may remand it back to the county to adjust in which case a new Notice of Overpayment would be sent.

When the final hearing decision is received, repayment will begin the following month in the amount specified by the hearing decision.

4640.00.00 TRANSMITTAL OF REPAYMENT

Payments must be mailed to:

FSSA Claim Repayment
P.O. Box 621007
Indianapolis, IN 46262-1007

All checks or money orders should be made payable to "State of Indiana". The person's name, claim number, RID number or Social Security Number should be on the payment. The check and/or money order are receipts of payment. Financial Management will post all payments. If no referral has been made prior to the repayment, an eligibility worker must complete the Overpayment Details-Referral Details page immediately so the claim can be established, and repayments can be accepted.

4650.00.00 BENEFIT RECOVERY FOR TRANSFER OF PROPERTY

A Benefit Recovery claim can be implemented when a transfer of property penalty was not applied timely to the member's case. A transfer of property by the member without adequate consideration is not permitted and if applied late it would not be considered an agency error.

There will be times when part of the penalty overlaps with a period where the individual was previously determined eligible and received Medicaid long-term care services. In this situation the claim would be initiated to recover the part of the nursing home per diem paid for by Medicaid. Completing the claim would cover the necessary advance notification to the member.

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[1] IC 12-15-2-19
[2] 42 CFR 433.36