STATE OF NEW YORK
DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 10 OHIP/ADM-9

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: November 22, 2010

SUBJECT: Reimbursement of Paid Medical Expenses Under 18 NYCRR §360-7.5(a)

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators
Temporary Assistance Staff

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Reimbursement Procedures – Medicaid Financial Management Unit, Tom Grestini, (518)473-5892

ATTACHMENTS:
Attachment I: Desk Aid: Reimbursement Policy
Attachment II: Sample Wording to Request a Claim Form
Attachment III: Claim Transmittal Form, OHIP-0031
Attachment IV: Medical Assistance Reimbursement Detail Form, OHIP-0032
Attachment V: Notice of Decision on Reimbursement of Medicaid Bills by the Medical Assistance Program, DSS-3869

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
	GIS 01 MA/046 88 ADM-31	18NYCRR 360-7.5(a)	42 CFR 435.905 & 435.914		GIS 03 MA/025 03 MA/019 02 MA/033 98 MA/011 95 MA/032

I. PURPOSE

This Office of Health Insurance Programs Administrative Directive (OHIP/ADM) advises social services districts of amendments to the Department's regulations at 18 NYCRR §360-7.5(a), which govern the circumstances in which direct reimbursement of paid medical bills may be made to eligible Medicaid or Family Health Plus recipients or their representatives. As amended, these regulations reflect several federal and State court decisions: the federal district court orders in Greenstein v. Dowling (1994) and Carroll v. DeBuono (1998) and the New York State Court of Appeals decision in Seittelman v. Sabol (1998). At the time of these court decisions, the Department issued several General Information System (GIS) messages that instructed social services districts regarding how they must implement the decisions. Social services districts should now consult the instructions that are contained in this directive. It consolidates the Department's prior GIS messages, and explains the amendments to 18 NYCRR §360-7.5(a).

II. BACKGROUND

In general, payment for medical care provided under the Medicaid Program is made to the enrolled Medicaid provider that furnished the care. However, the State's Medicaid regulations at 18 NYCRR §360-7.5 have long provided for two exceptions that enable Medicaid recipients, or their representatives, to be directly reimbursed for covered care and services.

Under the first exception, Medicaid recipients or their representatives may be directly reimbursed for covered care and services obtained during the recipients' retroactive eligibility periods. The retroactive eligibility period has two parts: a pre-application period and a post-application period. The pre-application period begins on the first day of the third month prior to the month in which the recipient applied for Medicaid and ends on the day the recipient applied for Medicaid. The post-application period begins on the day after the recipient applied for Medicaid and ends when the recipient receives the Common Benefit Identification Card (CBIC).

In the past, Department regulations at 18 NYCRR §360-7.5 provided that reimbursement for care and services received in the retroactive eligibility period could only be made if the recipient had obtained such services from enrolled Medicaid providers. This policy of limiting reimbursement only to services provided by enrolled providers was reflected in 88 ADM-31, "Medicaid Reimbursement for Certain Paid Medical Bills (Krieger v. Perales)."

The Carroll and Seittelman plaintiffs challenged this requirement, and the court ruled that 18 NYCRR §360-7.5 was invalid to the extent that it denied direct reimbursement for Medicaid covered services that a recipient, or the recipient's representative on behalf of the recipient, purchased from non-Medicaid enrolled providers during the pre-application part of the recipient's retroactive eligibility period.

This is the period that begins on the first day of the third month prior to the month in which the recipient applied for Medicaid and that ends on the date the recipient applied for Medicaid. Direct reimbursement may, however, be limited to the Medicaid rate. The provider must be otherwise lawfully qualified to provide the service and must not have been excluded or otherwise sanctioned under 18 NYCRR Part 515.

The court sustained the regulation to the extent that it denied direct reimbursement for services purchased from non-Medicaid enrolled providers during the post-application part of the recipient's retroactive eligibility period; that is, from the day after the recipient applies for Medicaid until the day the recipient receives his or her CBIC. However, the court also ruled that Medicaid applicants must be notified in writing on the day that they apply that they must obtain covered services during this period only from providers that are enrolled in the Medicaid program. In addition, reimbursement may be limited to the Medicaid rate.

Under the second exception to the rule that Medicaid payments are generally made only to the provider, the Department's regulations have long provided that Medicaid recipients or their representatives may be reimbursed when, due to social services district error or delay, recipients or their representatives must purchase services that would otherwise have been paid by Medicaid. Department regulations at 18 NYCRR §360-7.5 previously limited direct reimbursement due to social services district error or delay to the Medicaid fee or rate in effect when the service was rendered.

The Greenstein plaintiffs challenged the limitation of direct reimbursement to the Medicaid rate or fee in effect at the time medical services were received in cases where an erroneous determination or agency delay caused the recipient or the recipient's representative to pay for medical expenses that should have been paid for by the Medicaid program. The court ruled that 18 NYCRR §360-7.5(a)(1) was invalid to the extent that it limited direct reimbursement in cases of agency error or delay to the Medicaid rate or fee in effect at the time services were rendered.

The Department has amended its regulations at 18 NYCRR §360-7.5(a)(3) and (a)(4)to reflect these court decisions.

The Family Health Plus (FHPlus) statute [SSL §369-ee(5)(c)] provides that, except where inconsistent, the provisions of Title 11 (Medicaid) apply to applicants/recipients of FHPlus. Therefore, the provisions of 18 NYCRR §360-7.5(a)(3) also apply to cases of agency error or delay relating to FHPlus case processing. The provisions at 18 NYCRR §360-7.5(a)(4), which govern reimbursement for expenses paid in recipients' retroactive eligibility periods, do not apply to FHPlus. There is no retroactive eligibility for FHPlus enrollees.

III. PROGRAM IMPLICATIONS

For Medicaid eligible individuals, social services districts must reimburse the individual or his/her representative for paid medical expenses obtained from non-Medicaid enrolled providers during the three-month retroactive eligibility period and up until the day the individual applies for Medicaid. Documentation of income and/or resources, if appropriate, must be provided in order for eligibility to be determined for the three-month retroactive period.

Districts must ensure that every applicant is informed in writing when he or she applies that, should he or she be determined Medicaid eligible, direct reimbursement will be made for medically necessary Medicaid covered services the applicant, or the applicant's representative on the applicant's behalf, purchases during the period beginning immediately after the date of application and ending on the date the recipient receives his or her CBIC only when the recipient obtains the services from a provider enrolled in the Medicaid program.

Direct reimbursement to the recipient or the recipient's representative for Medicaid covered services purchased during the period beginning three months prior to the month of application, and ending on the day the recipient receives his or her CBIC, continues to be limited to the Medicaid rate or fee in effect when the service was provided even when the service was purchased from a non-Medicaid enrolled provider. The recipient must have been eligible for Medicaid when the services were received and must document payment for such services. The services must be medically necessary and must not exceed amount, duration and scope requirements; these requirements are generally at issue with respect to reimbursement requests for personal care services. Therefore, the district may have to obtain retroactive nursing and social assessments to determine the amount of personal care services that were medically necessary at the time, or obtain these documents from the agency that provided care to the recipient.

Direct reimbursement is not limited to the Medicaid rate or fee in instances where agency error or delay caused the recipient or the recipient's representative to pay for medical services which should have been paid under the Medicaid program. Instead, direct reimbursement must be made for the recipient’s, or such recipient’s representative’s, reasonable out-of-pocket expenditures.

For FHPlus eligible individuals, social services districts must reimburse the individual or his/her representative for paid medical expenses covered by FHPlus when a social services district's error or delay in the eligibility determination delays enrollment in a plan. Such reimbursement must not be limited to services provided by Medicaid enrolled providers or to the Medicaid rate or fee.

In all cases in which direct reimbursement is sought, the recipient or the client’s representative must provide proof that the bills for which direct reimbursement is sought were paid. Claims that are not supported by proof of payment, such as cancelled checks or notarized affidavits, are not reimbursable.

A desk guide for workers, which outlines reimbursement policy for the Medicaid and Family Health Plus programs, is attached to this directive (Attachment I).

IV. REQUIRED ACTION

A. Medicaid Eligibles – Reimbursement of Paid Medical Expenses

1. Expenses Paid in the Three-Month Retroactive Period: 18 NYCRR §360-7.5(a)(4)(i)

The procedures for reimbursement of paid medical expenses outlined in the New York State Fiscal Reference Manual, Volume 1, Chapter 7 and Volume 2, Chapter 5 remain generally unchanged for cases that are correctly determined eligible within the prescribed timeframes, with one exception. Reimbursement for paid medical expenses incurred in the period beginning three months prior to the month of application and ending on the day the recipient applies for Medicaid must not be restricted to expenses incurred from providers enrolled in the Medicaid program. However, all providers must be lawfully permitted under State law or regulation (i.e., duly licensed or certified) to provide the care, services or supplies for which the recipient is requesting reimbursement. The provider must also not have been excluded or otherwise sanctioned by the Medicaid program.

Reimbursement must be for services covered by the Medicaid program, and must not exceed the Medicaid rate or fee in effect when the service was provided. This applies even when the recipient, or the recipient’s representative, seeks reimbursement for services furnished by a non-Medicaid provider. Districts must ensure that all existing third party health insurance is exhausted and any potential third party coverage has been explored before reimbursement is provided.

Note: For new SSI recipients, reimbursement for paid medical expenses incurred in the period beginning three months prior to the month of application, and ending on the day the recipient receives the "Dear SSI Beneficiary" letter, must not be restricted to expenses incurred from providers enrolled in the Medicaid program.

2. Expenses Paid Subsequent to Application: 18 NYCRR §360-7.5(a)(4)(ii)

Social services districts must ensure that every applicant is informed in writing at the time of application that, if determined eligible, direct reimbursement will be made at the Medicaid rate for Medicaid covered services received after the date of application and before the date of receipt of the CBIC, only if furnished by a Medicaid enrolled provider. This includes all Temporary Assistance/Medicaid applicants and

Medicaid/FHPlus applicants who apply at outreach sites. The DSS-2921, "Application For: Public Assistance-Medical Assistance-Food Stamps-Services"; DOH-4220, "Access NY Health Care" application; and the LDSS-4148B, "What You Should Know About Social Services Programs" have been modified to include this information.

When a correct and timely decision regarding eligibility is made, all reimbursement to the recipient or the recipient's representative for Medicaid services furnished by a Medicaid enrolled provider during the period after application and prior to receipt of the CBIC is limited to the Medicaid rate or fee in effect when the service is provided.

Once a CBIC is received, no reimbursement may be made for expenses incurred after that date and paid by a recipient.

3. Expenses Paid Due to Agency Error or Delay: 18 NYCRR §360-7.5(a)(3)

When the applicant, or the applicant's representative, purchases medical services as a result of a social services district's error or delay, he or she may receive reimbursement in excess of the Medicaid rate or fee. Reimbursement for reasonable out-of-pocket expenditures may be made when, through no fault of the applicant:

a) a social services district fails to determine an applicant's Medicaid eligibility within the time period required under 18 NYCRR §360-2.4(a) and the district's delay in determining eligibility causes the applicant or the applicant's representative to pay for medical services that should have been paid by the Medicaid program; or

b) a social services district incorrectly determines an applicant ineligible for Medicaid, the incorrect determination causes the applicant or the applicant's representative to pay for medical services that should have been paid by the Medicaid program, and the social services district later reverses its incorrect determination due to the district discovering its own error or as the result of a fair hearing decision or court order.

Reimbursement under (a) must be made for documented bills incurred beginning 45 days after the date of application (90 days, when Medicaid eligibility is based on disability; 30 days when the application includes a pregnant woman or child under age 19) until the date the recipient receives a CBIC.

Reimbursement under (b) must be made for documented bills incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC.

Reimbursement may also be available when, due to social services district delay in the provision of authorized services, such as personal care services, the recipient, or the recipient's representative, must privately obtain covered services.

Reimbursement in cases of district error or delay must be made for reasonable out-of-pocket expenditures. This means that reimbursement may be made for the full out-of-pocket expenditures when these expenditures are considered to be reasonable. As a general rule, out-of-pocket expenditures that do not exceed 110 percent of the Medicaid rate are always reasonable and may be fully reimbursed. Out-of-pocket expenditures that exceed 110 percent of the Medicaid rate may also be reasonable under the particular circumstances and may be fully reimbursed. For example, the prevailing private pay rate in the community for the services may exceed 110 percent of the Medicaid rate or the recipient may have had to pay more to obtain services in a remote location or on a holiday or may demonstrate other special circumstances warranting full out-of-pocket reimbursement. The district may, but is not required to, request that the recipient, or the recipient's representative, explain why services could not have been obtained at a lesser cost. In all cases, however, the recipient or the representative must provide documentation that the expenses for which direct reimbursement is claimed were actually paid.

In addition, reimbursement in cases of district error or delay must not be limited to services provided by Medicaid enrolled providers. However, the provider must be lawfully qualified to provide the services and not be excluded or otherwise sanctioned by the Medicaid program.

B. FHPlus Eligibles – Reimbursement of Paid Medical Expenses

Because FHPlus benefits do not begin until eligibility is determined and enrollment in a plan has occurred, there is no reimbursement available under the FHPlus program during the three-month retroactive period.

There is also no reimbursement available for the period after application and prior to enrollment unless there has been an agency error in the eligibility determination or a delay in enrollment of an eligible person. Persons who are otherwise eligible under the Medicaid spenddown program during the three-month retroactive period through the date of enrollment in a FHPlus plan may be reimbursed for paid expenses in excess of their Medicaid spenddown, following the guidelines in Section IV.A of this directive.

1. **Expenses Paid Due to Agency Error (See GIS 02 MA/033)**

   In situations where the agency made an error in its initial determination, the recipient may be reimbursed for reasonable out-of-pocket expenses paid after the date of the agency's error. In determining the date on which an error occurred, the agency should use the date on the decision notice. Therefore, reimbursement for reasonable out-of-pocket expenses would be provided from the date of the decision notice until the first day the person's FHPlus enrollment is effective.

2. **Expenses Paid Due to Enrollment Delay (See GIS 02 MA/033)**

   After eligibility for FHPlus has been determined, the agency must process the plan enrollment by the 45th day following the eligibility decision if the decision was timely. If the decision was made after the proper timeframe, the agency must process the plan enrollment by the 45th day following the day the decision should have been made. When enrollment does not occur within these timeframes, the applicant is entitled to be reimbursed for reasonable out-of-pocket expenses paid from day 45, until the date enrollment is actually effective.

   Reimbursement to the recipient for both agency error and delay may be made for the reasonable out-of-pocket amount as described in Section IV.A.3. of this directive. The services must be those that are covered under the FHPlus plan. The provider of service does not need to participate in a FHPLus plan or be enrolled in the Medicaid program, but must be lawfully permitted to provide the care, services or supplies for which the recipient is requesting reimbursement.

C. **Reimbursement Procedures**

Social services districts have the option of reimbursing eligible recipients directly or requesting the Department to make payments for expenses that the districts have determined to be reimbursable. Districts should consult the New York State Fiscal Reference Manual, Volume 1, Chapter 7, and Volume 2, Chapter 5. When requesting the Department to make payments, use the OHIP-0031 (formerly the LDSS-3664), "Claim Transmittal Form" which has been revised, and is attached to this directive as Attachment III. Make sure to include the Medicaid provider identification number on the transmittal form unless direct reimbursement is to be made for services provided by a non-medical provider.

Questions regarding reimbursement can be directed to the Medicaid Financial Management Unit in the Department of Health, as indicated on the front page of this directive.

D. Notice Requirements

Information concerning the policy for direct reimbursement of medical expenses is contained in the LDSS-4148B: "What You Should Know About Social Services Programs". Social services districts must ensure that this information is provided to every Medicaid/FHPlus applicant, including those who apply at outreach sites, and to all Temporary Assistance applicants who also apply for Medicaid.

Individuals who request a determination of eligibility for reimbursement of paid medical bills must be sent the LDSS-3869: "Notice of Decision on Reimbursement of Medical Bills by the Medical Assistance Program." The OHIP-0032 (formerly the DSS-3870), "Medical Assistance Reimbursement Detail Form" (Attachment IV) or a local equivalent must be included with the notice.

E. Unpaid Expenses

There may be situations when a recipient has incurred a medical expense under the circumstances described in this directive, and payment has not yet been made. In this situation, payment must be made to the provider of service. Payment must only be made if the provider is enrolled in the Medicaid program. Department regulations prohibit payment to non-participating providers.

For Medicaid eligible individuals, districts must authorize the appropriate coverage for the date(s) of service in the Welfare Management System (WMS). The provider must submit the claim for payment to eMedNY in the usual manner.

For FHPlus eligible individuals, there is no mechanism to provide coverage in WMS prior to plan enrollment. Therefore, payments to providers for agency error and delay cannot be processed through eMedNY. When it is determined appropriate to pay such expenses, a Medicaid paper claim form that lists the proper Medicaid rates, codes and billing information must be completed. Attachment II of this directive provides sample wording districts may use to request the needed claim form from a provider. Upon completion of the appropriate paper claim form, the provider must return the form to the local district. Social services districts have the option of processing these claims and issuing payment to the provider, or requesting that the Department of Health process the claim and issue payment as outlined in Section IV.C. of this directive.

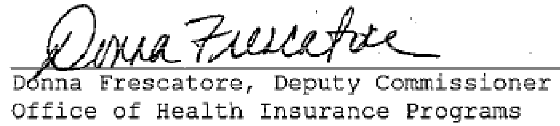
Local Departments of Social Services (LDSS) are reminded that billing statements from providers are not acceptable for payment of claims. The LDSS are required to submit the actual billing forms that the providers would submit to Medicaid for processing in the normal manner. It is also important to remember that the providers must be actively enrolled in the Medicaid program for unpaid bills to be paid.

V. SYSTEMS IMPLICATIONS

There are no systems implications.

VI. EFFECTIVE DATE

The provisions of this directive are effective immediately.



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