TO:	Local District Commissioners, Medicaid Directors
FROM:	Lisa Sbrana, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Electronic Submission of Reimbursement Claims
ATTACHMENT:	OHIP-0031 Pricing Spreadsheet
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to instruct local departments of social services (LDSS) of a change to the process for submitting reimbursement claims. This GIS will also introduce the new OHIP-0031 Pricing Spreadsheet to be used in place of the current Claim Transmittal, OHIP-0031.

Effective immediately, the process for submitting member claims for reimbursement of incurred out-of-pocket medical expenses will change. Local departments of social services will no longer submit the paper OHIP-0031 Claims Transmittal form and associated paper claim documentation to the Department of Health's (DOH) Medicaid Financial Management Unit (MFM). Instead, the LDSS will enter claim information into the attached OHIP-0031 Pricing Spreadsheet and electronically submit the spreadsheet to the state fiscal agent at eMedNYOfflineClaimsPricing@gdit.com. Multiple recipients' claims information can be populated and submitted on the same spreadsheet. The OHIP-0031 form will no longer be accepted and will become obsolete.

The following are the responsibilities of the LDSS and the Department of Health:

Local District Staff Responsibilities:

- Gather receipts and other appropriate information from enrollee requesting retroactive reimbursement. Confirm enrollee's eligibility for payment, using the current process.
- Complete data elements in columns A – AC in the spreadsheet (sample attached) for medical, pharmacy, durable medical items and services covered in the New York State Medicaid benefit plan. The columns on the spreadsheet correspond to the fields on the OHIP-0031 claim transmittal form.
    - Column Y indicates the category of approval for reimbursement determined by the local district upon review of the claim. Each claim submitted to the state fiscal agent for reimbursement must meet one of the criteria listed below. Claims not meeting the following criteria must be denied at the local district level:

        1. Claim occurred during the 90-day period prior to the date of the member's application and retro coverage has been issued.

2. Claim occurred between the application date and the date of CBIC issuance, and the service or medication was obtained from a Medicaid enrolled provider.
3. The medical service, pharmacy prescription, or durable medical equipment is not covered by Medicaid. (Use this category when there is a question as to whether the service is covered by Medicaid. In this instance, the district may submit the claim for verification by the state fiscal agent.)
4. Claim should be reimbursed in full due to agency error, agency delay, or Fair Hearing decision.

- Districts must issue the OHIP-3869 "Notice of Decision on Reimbursement of Medical Bills by the Medical Assistance Program" for any determinations made at the district level.

- When denying a claim, the district must issue the OHIP-0032 "Medical Assistance Reimbursement Detail Form" with the appropriate reason listed, in addition to the OHIP-3869.

- If a paid medical claim does not meet the criteria for approval of reimbursement, the district must not submit the claim electronically to the state fiscal agent on the OHIP-0031 Pricing Spreadsheet.

- Biweekly or more frequently, if needed, password protect the OHIP-0031 pricing spreadsheet and email it with return receipt requested, to the state fiscal agent at eMedNYOfflineClaimsPricing@gdit.com.

DOH Responsibilities:

- Upon receipt of the OHIP-0031 pricing spreadsheet, the state fiscal agent will review the spreadsheet for accuracy of the required data elements. Local Districts will receive confirmation of successful submission of the pricing spreadsheet or notice of rejection, if errors are found.

- Claims approved for payment by the state fiscal agent are referred to MFM. MFM sends notice to the enrollee indicating the amount reimbursed. The NYS Office of the State Comptroller (NYS-OSC) issues a reimbursement payment to the enrollee in the form of a check.

- The above changes in the reimbursement claims submission process have no impact on the LDSS role in preparing evidence packets and presenting agency evidence at Fair Hearings. For assistance in obtaining documentation for an evidence packet to present at a fair hearing contact your DOH local district liaison.

Local districts are reminded to reference 10 OHIP/ADM-9 when determining enrollee eligibility for reimbursement of paid medical expenses.

Please refer any questions to your local district liaison.