# FAMILY INDEPENDENCE ADMINISTRATION

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## POLICY DIRECTIVE #09-35-ELI

*(This Policy Directive Replaces PD #01-16)*

## MEDICAL BILLS FOR PERIOD PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

| **Date:** October 7, 2009 | **Subtopic(s):** Cash Assistance |
|---|---|

**AUDIENCE**

The instructions in this policy directive are for staff in Job Centers, and are informational for all other staff.

**REVISIONS TO ORIGINAL PROCEDURE**

This policy directive has been revised as follows:

- References to the now-obsolete Application/Job Profile form (**W-680B**) have been replaced with references to the Statewide Common Application (**LDSS-2921**).
- References to the now-obsolete Important Notice for Medicaid Applicants and Recipients (**M-42p**) have been replaced with references to the What You Should Know About Social Services Programs booklet (**LDSS-4148B**).
- The address for the transmittal of the Certification for Retroactive Medicaid Coverage (**M-42q**) form has been updated. Form **M-42q** has been revised to include the current NYC logo and terminology.
- The address for the transmittal of the Transmittal of Medical Bills (**M-42r**) has been updated. Form **M-42r** has also been revised to include the current NYC logo and terminology. “Public Assistance criteria” has been changed to “Medical Assistance criteria” throughout the form.

**POLICY**

Eligible applicants may be reimbursed for medical bills paid before their request for Medical Assistance (MA) and for medical bills paid up until the issuance of a Common Benefit Identification Card (CBIC) for Medicaid. Bills paid before the date of application for MA may be eligible for reimbursement if the services were received on or after the first day of the third month before the month that MA was requested.

For example, an individual who applied for MA on October 11, 2009, may be eligible for reimbursement of medical bills paid from July 1, 2009, until he/she receives a CBIC for Medicaid.

If the applicant paid his/her bills before applying for MA, the bills may be eligible for reimbursement even if the doctor or other provider does not take MA. After the date of application for MA, bills can be reimbursed only if the doctor or other provider takes MA.

To be eligible for reimbursement, the bills must be for necessary services that are generally covered by the MA program, such as doctors' visits, home care, hospital visits, and medication.

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**REQUIRED ACTION**

Applicants must be informed of the eligibility requirements for medical reimbursement. The What You Should Know About Social Services Programs (**LDSS-4148B**) booklet provides the applicant with information regarding the provisions for medical reimbursement. This booklet is included in all cash assistance application kits.

The JOS/Worker must review the Medical Information section in the Paperless Office System (POS) with the applicant.

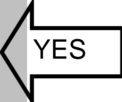
If the applicant has indicated verbally or in writing that he/she "has paid or unpaid medical bills within three months preceding the month of application," the Worker must:

- request that the applicant provide the original paid (in full or in part) medical bills and receipts (provide a return envelope for this purpose).
- answer the appropriate question in Paperless Office System (POS), as highlighted in the following screenshot:

FS POS 3.3 - [MEDICAL] 3:21:51 PM Friday, September 25, 2009

File Edit Tools Window Help

| INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING: | Yes | No |
|---|---|---|
| Has Daily Activity Limited because of an Illness/Temporary Disability or is Blind, Sick or Disabled ? | ⦿ | ○ |
| Has Paid Or Unpaid Medical Bills For The Three Months Preceding The Month Of This Application? | ⦿ | ○ |
| Has Any Type of Health/Hospital/Accident Insurance or Receives Assistance in Paying Medical Expenses? | ○ | ⦿ |
| Is Pregnant? | ○ | ⦿ |
| Has Any Medical Bills Or Medically Related Expenses? | ○ | ⦿ |




Response to Question

Who | Covered By Insurance: ○ Yes ○ No | Have Med Bills for Last 3 Months: ○ Paid ○ Unpaid ○ Both | Income/Resource In Last 3 Months: ○ Is the Same ○ Is Different

| Unpaid Bill For | | Budget Number | Effective Date |
|---|---|---|---|
| Month 1 | ☐ | | |
| Month 2 | ☐ | | |
| Month 3 | ☐ | | |

Document... Scan ☐

Comment...

OK Cancel

Entering a “yes” in the “Has Paid or Unpaid Medical Bills for the Three Months Preceding the Month of This Application” box will prompt the following Response to Question box:

Response to Question

Who: E Olga | Covered By Insurance: ○ Yes ⦿ No | Have Med Bills for Last 3 Months: ○ Paid ○ Unpaid ⦿ Both | Income/Resource In Last 3 Month: ⦿ Is the Same ○ Is Different

| Unpaid Bill For | | Budget Number | Effective Date |
|---|---|---|---|
| Aug 2009 | ☐ | | |
| Jul 2009 | ☐ | | |
| Jun 2009 | ☐ | | |

Document... Scan ☐

Comment...

OK Cancel

**Reimbursement of Paid/Partially Paid Medical Bills**

The JOS/Worker must ask the applicant whether his/her financial situation has been the same for the last three months, and select the appropriate answer in POS.

- If the applicant's answer is yes, the applicant is eligible for retroactive benefits. The Worker must:
  - have the applicant sign the Certification for Retroactive Medicaid Coverage (**M-42q**) form.
  - complete the Transmittal of Medical Bills (**M-42r**) form in duplicate and check the "Met MA Criteria for Retroactive Medicaid" box.
  - scan the signed Form **M-42r**, along with the applicant's original medical bills and receipts, into the electronic case record.

Refer to the CA and FS Resource Limits/Exemptions Desk Guide (W-204X) for information on resource limits.

Resource limits for CA and MA are the same.

- If the applicant's answer is no, or there is collateral information indicating income/resources, the Worker must review the individual's income and resources for the preceding three-month period to determine whether he/she would have qualified for MA during this period based on CA/MA gross and net income tests. The CA income and resource limits must be utilized in making this determination.
  - If the applicant appears to meet the criteria for reimbursement of medical bills, the Worker must:
    - have the applicant sign the Certification for Retroactive Medicaid Coverage (**M-42q**) form.
    - obtain all original medical bills and receipts and scan them into the electronic folder
    - complete the Transmittal of Medical Bills (**M-42r**) form in duplicate and check the "Met MA Criteria for Retroactive Medicaid" box.
    - scan the signed Form **M-42r** into the electronic case record.
  - If the applicant does not appear to meet the criteria for reimbursement of medical bills, the Worker must:
    - obtain all original medical bills and receipts and scan them into the electronic folder
    - complete the Transmittal of Medical Bills (**M-42r**) form in duplicate and check the "Failed to Meet MA Criteria for Retroactive Medicaid" box.
    - scan the signed Form **M-42r** into the electronic case record.

On the TAD window, the "MA From Date" field is disabled by default. The JOS/Worker may enable the field and enter an MA From Date that is different from the PA From Date, by checking the "Delink MA from PA?" checkbox, as shown below:

Upon receiving an applicant's original medical bills and/or receipts, regardless of whether the applicant appears to meet the criteria for reimbursement, the Worker must attach all original bills and receipts received to the **M-42r** form and send to:

Family Independence Administration
330 West 34th Street, 6th Floor
New York, NY 10001
Attn: FIA/MAP Liaison

(212) 630-9890

The FIA/MAP Liaison will forward the bills and receipts for review to:

MAP Reimbursement Unit
330 West 34th Street 9th floor
New York, N.Y. 10001

The MAP Reimbursement Unit will inform the applicant of the final decision regarding eligibility for medical bill reimbursement.

Upon case acceptance, the JOS/Worker must enter the first day of the third month prior to the date of application in Element **242** (MA FROM) and Element **342** (MA DATE) for each eligible applicant.

Unpaid Medical Bills

The JOS/Worker must inform the applicant that he/she must return any unpaid medical bills incurred within the three months preceding the month of application to the medical provider, along with a copy of the his/her CBIC, once the case is accepted. Medicaid will provide payment for eligible bills once the request for payment is received.

The Worker must also inform the applicant that medical bills incurred after the date of application and/or prior to the applicant's receipt of the CBIC can only be reimbursed if the medical provider is Medicaid enrolled.

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**PROGRAM IMPLICATIONS**

Paperless Office System (POS) Implications

There are no POS implications.

Food Stamp Implications

Please see Food Stamp Source Book, Section 5, for information about the criteria for aged/disabled designation.

Households that include at least one member who is aged or disabled are eligible for a Food Stamp (FS) deduction of medical expenses in excess of $35 per month (per household) which are not reimbursed by third-party insurers or under Medicare or Medicaid. Unpaid medical bills may be included in this deduction. Other household members, spouses or other persons receiving FS as a dependent of a recipient of Supplemental Security Income (SSI) or disability benefits may not claim their medical costs as deductions. Participants receiving emergency SSI benefits based on presumptive eligibility may claim their medical costs as deductions.

If an eligible aged/disabled participant or emergency SSI recipient has past-due medical bills that were not previously allowed as medical deductions, he/she is permitted to claim the bills as deductions at his/her next certification or recertification.

The household may voluntarily report medical expenses that come due during the certification period and have them considered in determining the monthly medical deduction for the remainder of the certification period, but it cannot be required to report these expenses.

The household may also report at recertification the medical expenses that were incurred during the household's certification and have them considered in determining the monthly medical deduction for the new certification period.

Medicaid Implications

There are no Medicaid implications.

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**LIMITED ENGLISH SPEAKING ABILITY (LESA) AND HEARING-IMPAIRED IMPLICATIONS**

For Limited English-Speaking Ability (LESA) and hearing-impaired applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #09-14-OPE and PD #08-20-OPE.

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**FAIR HEARING IMPLICATIONS**

Avoidance/ Resolution

Applicants are entitled to request a Fair Hearing if they believe that payment of their medical bills was inappropriately denied. Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants must receive adequate notification of all actions taken on their cases.

Conferences

An applicant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time.

If an applicant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the applicant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

The FH&C AJOS/Supervisor I will listen to and evaluate the applicant's complaint. After reviewing the case file and discussing the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor, he/she will determine if the action taken was correct. If the determination is that the action taken is correct, the FH&C AJOS/Supervisor I will explain the reason for the Agency's action(s) to the applicant. If the explanation is accepted, no further action is necessary. The AJOS/Supervisor I must complete a Conference Report (**M-186a**).

If the determination is that the action taken was incorrect or correct but lacking the supporting documentation, the FH&C AJOS/Supervisor I will forward all verifying documentation submitted by the applicant to the appropriate JOS/Worker for corrective action to be taken.

Evidence Packets

Should the applicant choose to continue his/her appeal by requesting or proceeding to a Fair Hearing, already requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

All Evidence Packets must include the POS **LDSS-2921** form; the scanned **LDSS-2921** form, if applicable; Action Taken On Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage And Services Part A (NYC) (**LDSS-4013A NYC**); Action Taken On Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC) Part B (**LDSS-4013B NYC**); all submitted medical bills and receipts dated three months prior to the date of application; Welfare Management System (WMS) screen printouts; and any other documentation relevant to the action(s) taken.

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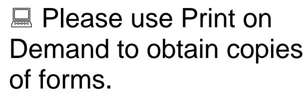
**REFERENCES**

18 NYCRR 360-7.5 (a)(5)
Food Stamp Source Book (FSSB), Section 5 and Section 11

## ATTACHMENTS


Please use Print on Demand to obtain copies of forms.

| | |
|---|---|
| **M-42q** | Certification for Retroactive Medicaid Coverage (Rev. 10/7/09) |
| **M-42q (S)** | Certification for Retroactive Medicaid Coverage (Spanish) (Rev. 10/7/09) |
| **M-42r** | Transmittal of Medical Bills (Rev. 10/7/09) |

Form M-42q LLF
Rev. 10/7/09

NYC Human Resources Administration | Family Independence Administration
Department of Social Services

# Certification for Retroactive Medicaid Coverage

Re:

Case Name:______________________________ Case Number:______________

Address:________________________________ Telephone:______________

This is to certify that the information I have given to the Human Resources Administration as a basis for Medicaid coverage for the three-month period from ______________ to ______________, prior to my application for assistance is true and correct. The following information applies to my case (check one):

☐ My income and resources during the three-month period prior to my application were the same as stated on my application for assistance.

☐ My income and resources during the three-month period from ____________ to ____________, prior to my application were not the same as stated on my application for assistance, but have been determined to be within the allowable limits for receipt of retroactive Medicaid coverage.

SAMPLE

Applicant's Signature:______________________________ Date:______________

Worker's Signature:______________________________ Date:______________

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

# Certificación Retroactiva para Medicaid

Re:

Nombre del Caso: ______________________ Número del Caso: ______________

Dirección: ______________________________ Teléfono: ______________

Por el presente certifico que la información que he dado a la Administración de Recursos Humanos como base de mi cobertura de Medicaid durante los 3 meses desde ______________ hasta ______________ antes de solicitar asistencia, es verídica y correcta. La información a continuación corresponde a mi caso (marque una):

☐ Mi ingreso y los recursos durante los tres meses antes de solicitar asistencia eran iguales a la cantidad indicada en mi solicitud para asistencia.

☐ Mi ingreso y recursos durante los tres meses de ______________ a ______________antes de solicitar asistencia no eran iguales a la cantidad indicada en mi solicitud para asistencia, pero ha sido determinada dentro de los límites permisibles para recibir Medicaid retroactivo.

Firma del Solicitante: ______________________________ Fecha: ______________

Firma del Trabajador: ______________________________ Fecha: ______________

SAMPLE

Form M-42r
Rev. 10/7/09

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ____________________

Case Number: ____________________

Case Name: ____________________

Center: ____________________

Caseload: ____________________

Worker's Telephone Number: ____________________

To: Family Independence Administration
330 West 34th St., 6th floor
New York, NY 10001
Attn: FIA/MAP Liaison

# Transmittal of Medical Bills

For the Three-month Period Prior to Application

Re:

Case Name: ____________________ Case Type: ____________________

Address: ____________________ Telephone Number: ____________________

SAMPLE

**Check appropriate box below and attach original bills and receipts.**

☐ **Met Medical Assistance (MA) Criteria for Retroactive Medicaid**

Appended are paid medical bills incurred by the above-referenced participant during the three-month period from ____________________ to ____________________, prior to his/her application for assistance. Please arrange for these bills to be reviewed and issue reimbursement, where appropriate.

☐ **Failed To Meet MA Criteria for Retroactive Medicaid**

Appended are the paid medical bills incurred by the above-referenced participant during the three-month period from ____________________ to ____________________, prior to his/her application for assistance. Although this participant failed to meet the MA eligibility criteria for retroactive Medicaid coverage, please forward these bills to Medicaid for review. Income and resources for the three-month period prior to application were as follows:

| | Month | Income | Resources |
|---|---|---|---|
| 1st month prior to application: | __________ | __________ | __________ |
| 2nd month prior to application: | __________ | __________ | __________ |
| 3rd month prior to application: | __________ | __________ | __________ |

Worker's Name: ____________________ Date: ____________________

Supervisor: ____________________ Date: ____________________