STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

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

CONTACT PERSON:

Local District Liaison
Upstate: (518)474-8887
NYC: (212)417-4500

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.

Donna Frescatore, Deputy Commissioner
Office of Health Insurance Programs

REIMBURSEMENT POLICY FOR MEDICAID/FHPLUS

MEDICAID	Paid Bills (to Recipient):	Unpaid Bills (to Provider):
Retro period (Begins 3 months prior to month of application and ends on the date of application)	Yes – MA services from MA enrolled or non-MA enrolled provider; payment limited to MA rate	Yes - to MA enrolled provider (payment through eMedNY)
Application date to receipt of MA ID Card	Yes – MA services from MA enrolled provider only; payment limited to MA rate	Yes - to MA enrolled provider (payment through eMedNY)
Card receipt forward	No	Yes - to MA enrolled provider (payment through eMedNY)
Agency Error (If timely, from date of erroneous decision until receipt of ID card; if not timely, follow delay rule)	Yes – MA services from MA enrolled or non-MA enrolled provider; reasonable out-of-pocket expenses	Yes - to MA enrolled provider (payment through eMedNY)
Agency Delay (From date decision should have been made, i.e., 30/45/90 days, until receipt of ID card)	Yes – MA services from MA enrolled or non-MA enrolled provider; reasonable out-of-pocket expenses	Yes - to MA enrolled provider (payment through eMedNY)

FAMILY HEALTH PLUS	Paid Bills (to Recipient):	Unpaid Bills (to Provider):
Retro period (None)	N/A	N/A
Application date to timely enrollment	N/A	N/A
Date of Enrollment forward	No	Yes - to FHPlus provider (payment through plan)
Agency Error (If timely, from date of erroneous decision until enrollment; if not timely, follow delay rule)	Yes – FHPlus services from any qualified provider; reasonable out-of-pocket expenses	Yes – to MA enrolled provider at MA Rate; FHPlus services only (off-line process)
Agency Delay** (From date enrollment should have occurred until enrollment)	Yes – FHPlus services from any qualified provider; reasonable out-of-pocket expenses	Yes - to MA enrolled provider at MA Rate; FHPlus services only (off-line process)

** Enrollment must occur by the 45th day after a timely decision or, if decision is not timely, by the 45th day after the date the decision should have been made (i.e., 75 days from date of application if the application includes a pregnant woman or child under the age of 19; 90 days from date of application for all others).

Updated 10/10

ATTACHMENT II

Date

Provider Name
Provider Address
City, New York 00000

Recipient:
Date of Service(s):
CIN#:

Dear Medicaid Provider:

The above named recipient was determined eligible for the Family Health Plus program during the time period the enclosed medical expenses were incurred. However, because the recipient's enrollment in the program had not been completed on the date of service, we are unable to process payment of these expenses in the normal manner.

In order for us to make payment for the enclosed medical expense(s), you must submit a Medicaid paper claim form that lists the proper Medicaid rate(s), codes and billing information.

Please return the completed Medicaid paper claim form(s) to this Department (hospitals should use their UB92 for inpatient hospital charges with ICD-9 codes and medical providers should submit their own paper claim form(s) with CPT4 codes including diagnosis codes) so that we can process your payment.

If you require copies of any claim forms, you can contact the Computer Science Corporation as follows:

(800) 522 – 1892 Institutional Unit (hospitals, nursing homes, clinics, home health agencies)

(800) 522 – 5518 Practitioner Unit (doctors, dentists, podiatrists, etc.)

(800) 522 – 5535 Professional Unit (pharmacies and medical equipment vendors)

Upon receiving the appropriate claim form, your payment will be processed as soon as possible.

Thank you for your cooperation.

CLAIM TRANSMITTAL FORM

LOCAL DISTRICT:		**Page ___of ____**	
RECIPIENT NAME:	CLAIMANT'S SSN:	APPLICATION DATE:	ELIGIBLE From: To:
RECIPIENT ADDRESS:		CLIENT IDENTIFICATION NO.	
REPRESENTATIVE NAME, ADDRESS, AND SOCIAL SECURITY NO. (if applicable)			

NAME AND ADDRESS OF SERVICE PROVIDER	MEDICAID PROVIDER ID#	DESCRIPTION OF SERVICE PROVIDED (For Prescription Drugs, Show Name, Strength and Quantity)	DATE OF SERVICE (MO/DAY/YR)	TOTAL BILL	INSURANCE PAYMENT	AMOUNT PAID (After Insurance Payment and Spend-down, if any)

I certify that the above-named recipient is eligible for reimbursement of paid medical expenses and/or the above-named FHPlus provider is eligible for reimbursement for unpaid medical expenses for the time period indicated above. This claim is a result of:

- ☐ Expenses paid due to agency error
- ☐ Expenses paid due to agency delay
- ☐ Expenses paid in the 3 mo. period prior to the mo. of application (limited to Medicaid rate/fee)
- ☐ Expenses paid between the date of application and receipt of the CBIC (limited to Medicaid enrolled providers and Medicaid rate/fee)
- ☐ FHPlus unpaid expenses
- ☐ Other _____
  _____

CASE TYPE_____

DATE COMPLETED_____

X _____
SIGNATURE OF LDSS ELIGIBILITY WORKER

MEDICAL ASSISTANCE REIMBURSEMENT DETAIL FORM

_____Department of Social Services Recipient Name: _____

Case #:_____

BILLS SUBMITTED FOR PAYMENT			REASON WE WILL NOT PAY OR WILL PAY ONLY PART OF BILL			
DATE OF BILL	NAME OF PROVIDER DESCRIPTION OF SERVICE	AMOUNT OF BILL	MAXIMUM PAYABLE BY MEDICAL ASSISTANCE	TPHI SPENDDOWN AMOUNT	AMOUNT WE WILL PAY	OTHER: - Service Dates Not Covered - Ineligible Service - Missing Information - Etc.

Attachment V
MA Only

LDSS-3869 (9/10)

NOTICE OF DECISION ON REIMBURSEMENT OF MEDICAL BILLS BY THE MEDICAL ASSISTANCE PROGRAM

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This notice is to advise you of this Department's decision regarding reimbursement of medical bills.

☐ The provider(s) listed on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail form) is (are) to be paid for services to you or your dependents for the amount(s) shown. The form details the bill(s) you sent us.

☐ A check for $ _____ is being mailed to you. This represents a reimbursement (payment) to you for medical services which you paid. The enclosed form details these reimbursement amounts.

These payments are being made as a result of your fair hearing, agency (re)consideration, or as a result of a court case, pursuant to the notice(s) dated _____.

In computing the amount of these checks, the Department reviewed the bill(s) sent to us. These bills totaled $_____. Denied bills, if any, are listed along with the reason(s) for denial on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail form).

The remaining bills, if any, are to be paid at the Medical Assistance rate in effect at the time the services were rendered (less your excess income, if any).

☐ The bills submitted are not reimbursable by the Medical Assistance Program. The reason(s) for denial are listed on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail Form).

The law and/or regulation which allow us to do this is 18 NYCRR 360-7.5(a)(1).

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

LDSS-3869 (9/10) Reverse

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

3) **On-Line:** Complete and send the online request form at: **https://www.otda.state.ny.us/oah/forms.asp. OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

LDSS-3869 S (9/10)

NOTIFICACIÓN DE LA DECISIÓN DE REEMBOLSO DE FACTURAS MÉDICAS POR PARTE DEL PROGRAMA DE ASISTENCIA MÉDICA

FECHA DE LA NOTIFICACIÓN:	NÚMERO DE CASO	NÚMERO CIN	NOMBRE Y DIRECCIÓN DE AGENCIA/CENTRO U OFICINA DE DISTRITO
CASO A NOMBRE DE (y nombre de persona a cargo, de estar presente) Y DOMICILIO			NÚMERO GENERAL DE TELÉFONO PARA PREGUNTAS O AYUDA _____ Conferencia con la Agencia _____ Información sobre Audiencia Imparcial y Asistencia _____ Acceso a los Archivos _____ Información sobre Asistencia Legal _____

NO. DE OFICINA	NO. DE UNIDAD	NO. DE TRABAJADOR(A)	NOMBRE DE LA UNIDAD O PERSONA A CARGO DEL CASO	NO. DE TELÉFONO

Esta notificación tiene por objeto comunicarle la decisión de este Departamento en relación con el reembolso de facturas médicas.

☐ El/los profesional(es) médico(s) especificado(s) en el formulario adjunto OHIP-0032 (Detalles del Reembolso por Parte de Asistencia Médica) debe(n) recibir pago por servicios prestados a usted o a sus dependientes, por el/los monto(s) indicado(s). El formulario detalla la(s) factura(s) que usted nos envió.

☐ A usted se le enviará por correo un cheque por el monto de $ _____. Esto representa un reembolso (pago) del dinero que usted pagó por servicios médicos. El formulario adjunto detalla los montos de estos reembolsos.

Estos pagos se efectúan como resultado de la audiencia imparcial, (re)consideración de la agencia, o resolución judicial, de acuerdo a lo estipulado en la(s) notificación(es) con fecha(s) _____.

En el proceso de cálculo del monto de estos cheques, el Departamento revisó la(s) factura(s) recibidas. El total de estas facturas es $_____. Las facturas rechazadas, de haberlas, están indicadas, junto con la(s) razón(es) de tal decisión, en el formulario adjunto OHIP-0032 (Detalles del Reembolso por Parte de Asistencia Médica).

Las facturas restantes, si cualquiera, deberán ser pagadas de acuerdo al índice de Asistencia Médica en vigencia al momento en que los servicios fueron prestados (menos sus ingresos excesivos, de haberlos).

☐ Las facturas presentadas no son reembolsables por parte del Programa de Asistencia Médica. La(s) razón(es) de esta negativa se indica(n) en el formulario adjunto OHIP-0032 (Detalles del Reembolso por Parte de Asistencia Médica).

La ley y/o reglamento que nos permite tomar esta decisión es 18 NYCRR 360-7.5(a)(1).

LA REGLAMENTACIÓN ESTIPULA QUE USTED DEBE NOTIFICAR INMEDIATAMENTE A ESTE DEPARTAMENTO SOBRE CUALQUIER CAMBIO EN SUS NECESIDADES, RECURSOS, CIRCUNSTANCIAS DE VIDA O SU DOMICILIO

USTED TIENE EL DERECHO DE APELAR EN CONTRA DE ESTA DECISIÓN
ASEGÚRESE DE LEER EL REVERSO DE ESTA NOTIFICACIÓN SOBRE CÓMO APELAR EN CONTRA DE ESTA DECISIÓN.

LDSS-3869 S (9/10) Reverso

DERECHO A UNA CONFERENCIA: Usted puede solicitar una conferencia para examinar la decisión tomada. Si desea solicitar una conferencia, hágalo lo más pronto posible. Si en la conferencia nos percatamos que nuestra decisión es incorrecta; o si en base a la información que usted nos brinde, decidimos cambiar la decisión tomada, tomaremos la medida correctiva y le enviaremos una nueva notificación. Puede solicitar una conferencia llamando al número de teléfono que aparece en la primera página de esta notificación o enviándonos una carta a la dirección que aparece en esa misma página. Ese número es solamente para solicitar una conferencia con la agencia y ***no es la manera de solicitar una audiencia imparcial.*** Si solicita una conferencia, todavia tiene derecho a una audiencia imparcial. Lea la siguiente información sobre audiencias imparciales.

DERECHO A UNA AUDIENCIA IMPARCIAL: Si usted cree que la decisión descrita anteriormente es incorrecta, puede solicitar una audiencia estatal imparcial de las siguientes maneras:

1) **Por teléfono:** Llame al número de teléfono estatal: 800 342-3334 *(FAVOR DE TENER A MANO ESTA NOTIFICACIÓN CUANDO LLAME).*

2) **Por fax:** Envíe una copia de esta notificación al (518) 473-6735

3) **Por internet:** Rellene una petición electrónica en el siguiente sitio: **http://www.otda.state.ny.us/oah/forms.asp**

4) **Por escrito:** Rellene este aviso y envíe una copia a: *Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.* Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. La decisión de la agencia es incorrecta porque: _____

Nombre (en letra de molde): _____ Número de caso: _____

Domicilio: _____ Teléfono: _____

Firma del cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS A PARTIR DE LA FECHA DE ESTA NOTIFICACIÓN PARA SOLICITAR UNA AUDIENCIA IMPARCIAL

Si usted solicita una audiencia imparcial, el Estado le enviará una notificación informándole dónde y cuándo se llevará a cabo la audiencia. Usted tiene derecho a ser representado por un asesor legal, un pariente, un amigo(a) u otra persona, o de representarse así mismo(a). En la audiencia, usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia escrita y oral que demuestre por qué no se debe tomar la medida, como también la oportunidad de interrogar a toda persona que compadezca en la audiencia. Además, usted tiene el derecho de presentar testigos que avalen su caso. Le sugerimos traer consigo todo documento pertinente que avale su caso, tales como: talonario de cheques de pago, recibos, facturas médicas, facturas de calefacción, comprobantes médicos, cartas, etc.

ASISTENCIA LEGAL: Si necesita asesoría legal gratuita, podría obtenerla llamando al número local de la Sociedad de Ayuda Legal o cualquier otro grupo de abogacía. Puede localizar la Sociedad de Ayuda Legal o un grupo de abogacía en las Páginas Amarillas del directorio telefónico bajo *«Lawyers»* (abogados), o llamando al número que aparece en la primera página de esta notificación.

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: En preparación para la audiencia, usted tiene derecho a revisar el archivo de su caso. Si nos llama o nos escribe, le brindaremos, sin cargo, copias de documentos contenidos en su archivo; los mismos que entregaremos al funcionario a cargo de la audiencia imparcial. Además, si nos llama o nos escribe, le brindaremos, sin cargo, copias de otros documentos contenidos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al número de teléfono de Acceso a Archivos que aparece en la parte superior de la primera página de esta notificación, o mande una carta a la dirección indicada en esa misma página.

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada de la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente lo solicita.

INFORMACIÓN: Si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en la **primera página** de este aviso o mande una carta a la dirección que figura en esa misma página.

ATENCIÓN: Los niños menores de 19 años de edad que no reúnen los requisitos de Child Health Plus A o de algún otro seguro médico, podrían reunir los requisitos del Seguro de Salud Child Health Plus B (Child Health Plus B). El seguro brinda atención y cuidados de salud para niños. Si desea información llame al 1-800-522-5006.