TO: All Local District Commissioners, Medicaid Directors

FROM: Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

SUBJECT: Family Health Plus Reimbursement for Errors and Delays

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison: Upstate (518) 474-8216
NYC (212) 268-6855

On August 7, 2003, GIS 03 MA/019 was issued to clarify the Department's policy regarding payments to providers for medical expenses incurred by Family Health Plus (FHPlus) eligible persons as a result of agency error or delay. This GIS provides further instructions as to how to process such payments.

As stated in GIS 03 MA/019, the local districts have the option of processing claims and issuing payment to providers themselves, or having the Department of Health process the claims and issue the required payments.

We have been advised by staff in our Fiscal Management Group that bills submitted by a recipient often do not contain sufficient information to allow us to correctly process payment to the provider. Therefore, we are amending our instructions to local districts.

When a FHPlus recipient requests payment for expenses incurred as a result of an agency error or delay, the local social services district must first confirm that it is appropriate to pay the expenses (i.e., the expense was incurred as the result of the district's error or delay (see GIS 02 MA/033), the service is covered by FHPlus and the provider is a Medicaid enrolled provider). If expenses do not meet the criteria for reimbursement, payment must be denied by the district, with appropriate notice to the recipient. 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. Upon completion of the paper claim form, the provider must return the appropriate paper claim form to the local district. When the local district opts to have this Department process the claim, the local district must attach a Claim Transmittal Form (LDSS 3664) and submit the claim to the following address:

New York State Department of Health
Attn: Medicaid Financial Management Unit
Corning Tower, Room 1237
Albany, New York 12237

The e-mail version of this GIS includes an attachment with sample wording that you may wish to use to request the needed claim form from a provider. The e-mail version also includes a desk guide for workers, which outlines reimbursement policy for the Medicaid and Family Health Plus programs.

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.

REIMBURSEMENT POLICY FOR MEDICAID/FHPLUS

MEDICAID	Paid Bills:	Unpaid Bills:
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 at MA Rate
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 at MA Rate
Card receipt forward	No	Yes - to MA enrolled provider (payment through MMIS)
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 at MA Rate
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 at MA Rate

* In cases of agency delay, reimbursement may be available to the recipient for expenses incurred from a non-enrolled provider, if the recipient demonstrates why the delay caused him/her to receive services from a non-enrolled provider.

FAMILY HEALTH PLUS	Paid Bills:	Unpaid Bills:
Retro period (None)	N/A	N/A
Application date to timely enrollment	N/A	N/A
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 MA enrolled or non-MA enrolled 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 MA enrolled or non-MA enrolled 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).