OTHER ELIGIBILITY REQUIREMENTS
RETROACTIVE PERIOD

PAYMENT OF UNPAID MEDICAL BILLS

Description: Payment of unpaid medical expenses may be made to Medicaid enrolled providers for covered care and services obtained during the recipients' retroactive eligibility periods (pre and post -application periods).

Policy: Social services districts must authorize appropriate periods of eligibility for Medicaid eligible individuals who incurred qualifying medical expenses during the three-month retroactive eligibility period.

References:

ADM 10 OHIP/ADM-9

Dept. Regs. 18 NYCRR 360-7.5 (a)

GIS 03 MA/025
03 MA/019
02 MA/033
98 MA/011
95 MA/032

Interpretation:

Retroactive Period:

Payment may be made for unpaid bills that are:

- Incurred during the **retroactive** eligibility period, which begins on the first day of the third month prior to the month in which the individual applied for Medicaid and ends on the date the individual applies for Medicaid;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

Post-Retroactive Period:

Payment may be made for unpaid bills that are:

- incurred during the **post-retroactive** eligibility period, which begins on the date of application and ends on the date the individual receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope, AND
- provided by Medicaid enrolled providers.

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NOTE: Because Family Health Plus benefits do not begin until eligibility is determined AND enrollment in a plan has occurred, there is no payment of unpaid bills available under the FHPlus program during the three-month retroactive period. However, individuals 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.

Payment is limited to Medicaid enrolled providers, at the Medicaid rate, after application of ALL third party reimbursement.

Agency Delay:

Payment may be made for unpaid bills that are:

- incurred beginning 45 days after the date of application and before the receipt of a CBIC card; or
- incurred beginning 30 days after the date of application when the application includes a pregnant woman or child under the age of 19 and before the receipt of a CBIC card; or
- incurred beginning 90 days after the date of application when the application is based on disability and before receipt of a CBIC card; and
- medically necessary;
- covered by the Medicaid Program ;
- within Medicaid requirements for amount duration and scope; and
- provided by Medicaid enrolled providers.

Agency Error:

Payment may be made for unpaid bills that are:

- incurred from the date of the social services district's incorrect determination until the date the applicant receives a CBIC card;
- medically necessary;
- covered by the Medicaid Program;
- within Medicaid requirements for amount duration and scope; and,
- provided by Medicaid enrolled providers.

To obtain payment for bills incurred during the retroactive periods, the recipient must document income and resources, as appropriate, in order for eligibility to be determined for the appropriate retroactive period. Once eligibility has been determined, appropriate periods of eligibility are recorded in WMS to allow payment to Medicaid enrolled providers.

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FHPlus: 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 the LDSS has determined that it is appropriate to pay expenses, a Medicaid paper claim form that lists the proper Medicaid rates, codes and billing information must be completed by the provider and submitted to the district. Such claims are paid either by the district or the Department, consistent with the choice made by the district.

NOTE: Billing statements from enrolled providers are not acceptable for payment of claims. Providers/districts must submit actual billing forms ordinarily submitted to eMedNY for processing.