

0302**THE APPLICATION PROCESS****0302.05****THE REQUEST FOR MEDICAL ASSISTANCE**

REV:01/2002

The application process begins when an individual or his/her representative contacts the agency to request Medical Assistance and ends with:

- o a decision by the Department of Human Services to approve or to deny assistance; or,
- o a decision by the applicant to withdraw his/her request for assistance.

The purpose of the application process is to ensure that the application is fully considered and acted upon in a timely manner. It provides the individual an opportunity to state his/her needs and to learn what the agency can do in response.

It also provides the agency an opportunity to explain the individual's responsibilities in relation to the agency and the need to inform the agency of changes in circumstances which may affect eligibility for Medical Assistance.

A request for assistance may be received in a DHS office in person, by phone or by mail. When a request is received, a DHS staff member gives or mails the individual an application packet.

A request for Medical Assistance on behalf of a pregnant woman or family with a child under the age of nineteen (19) years may be received in locations other than district offices through outreach workers known as Family Resource Counselors (FRC's).

Currently FRC's are located in twelve participating community health centers and three hospital clinics statewide. The Family Resource Counselors screen pregnant women and young children for potential eligibility for Medical Assistance (and the Rite-Care, WIC, and Food Stamp programs) and assist those thought to be eligible in the application process. The goal is to help non-cash assistance eligibles to obtain early pre-natal and pediatric health services.

SECTION 0302**THE APPLICATION PROCESS**

0302.05.05 THE REQUEST FOR A MEDICARE PART D APPLICATION

EFF:01/2006

An individual who does not qualify for Medicaid or his/her representative has the option to contact either a Social Security Administration Office or a Department of Human Services Office to request an application for the Medicare Part D Program. This request may be received at a DHS office in person, by phone or by mail. When a request is received at a DHS Office, a DHS staff member gives or mails the individual an application for the Medicare Part D Program. At this time the DHS staff member should also provide the individual with an MPP-1 Application Form so that the individual may be reviewed for QMB or SLMB eligibility.

Completed applications may be submitted to either a Social Security Administration Office or a Department of Human Services Office. If a Medicare beneficiary insists that DHS process the application, the DHS representative is required to do so. If the beneficiary insists that the DHS representative process the application, the DHS representative must complete the process within sixty (60) days from the date the application is received.

0302.10

CONTENTS OF THE APPLICATION PACKET

REV:12/2001

The application packet consists of the following documents:

INDIVIDUALS/COUPLES/QMB'S/QDWI'S	FAMILIES
DHS-1 Application Form/ DHS-2 Statement of Need	DHS-1 Application Form/ DHS-2 Statement of Need Or, MARC-1 Application Packet
MA Booklet	DHS-14 Office Locations
DHS-14 Office Locations	R-11 EPSDT Information
QMB-2 Information for QMB's	
Transportation Information	
Return Addressed Stamped Envelope	Return Addressed

Stamped Envelope

This packet provides information about the agency, the conditions under which Medical Assistance is provided and an applicant's rights and responsibilities under the law. The family packet also provides an informational brochure on the Department of Health's WIC Program (women, infants and children's supplemental food program in Rhode Island) and the locations of participating WIC facilities.

The DHS-1 and the DHS-2 are the application documents for individuals, (including a blind or disabled child), couples and families which serve as the basis of the MA eligibility determination. These forms and other supplementary forms, as appropriate, constitute an application for Medical Assistance.

0302.10.05 Assistance in Completing the Application

REV:06/1994

An applicant is informed that a friend, relative, attorney, guardian or legal representative may assist in completing the application forms and that, if needed, an Eligibility Technician is also available for assistance.

Occasionally a completed application form is received in the district or regional office through the mail without any prior request for assistance. This occurs when credit departments of hospitals provide patients with the forms, and when Central Office mails an application form to an individual being terminated on SSI.

In such instances, there must be the usual response to the application for Medical Assistance:

- o The date of receipt must be noted on the application form;
- o The applicant must be contacted, where appropriate, for information relative to eligibility;
- o The application must be acted upon within the applicable time frame; and
- o A notice of action must be provided to the applicant.

0302.10.10 Who Must Sign the Application

REV:11/2000

The following individuals must sign the application:

- o When two spouses are living together, both spouses must sign the application form;
- o When two parents of a dependent child are living together, both parents must sign the application form.

The following individuals may sign the application form:

- o A relative or non-relative caretaker may file an application form for a child under the age of (19);
- o An individual under the age of nineteen (19) who is living independently (and not merely "temporarily absent" from home as defined in Section 0328.10.10) may file an application;
- o A relative may file an application on behalf of a deceased individual for retroactive coverage.

0302.15

DECISION ON ELIGIBILITY

REV:08/1999

A decision on a Medical Assistance application for families and for aged and blind individuals is made within THIRTY (30) DAYS of the receipt of the application by the department. An eligibility decision for disabled individuals is made within NINETY (90) DAYS of the receipt of the application by the department.

An eligibility decision must be made within the above standards except in unusual circumstances when good cause for delay exists.

Good cause exists: 1) when the agency representative cannot reach a decision because the applicant or examining physician delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms MA-63 (Physician's Report), AP-70 (Information for Determination of Disability) and DHS-25M (Release) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or 2) when there is an

administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: 1)the reason for delay; and 2)the opportunity for an expedited hearing to contest the delay.

The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

For applications which require a determination of resources (i.e., all SSI related applications and some family-related applications), at least ONE (1) AP-91 FORM is sent to determine the amount of money in, or existence of, a bank account. The form is sent to the bank where the individual has or had an account. If no account is declared, the AP-91 is sent to the banking institution most likely to have been used by the individual considering the location of home and/or employment.

At redetermination, at least ONE (1) AP-91 form is sent, but to an institution, such as a bank or credit union, not selected at the time of the application.

If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone or in person for clarification, additional information or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps s/he or the agency must take. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign AP-25, Release of Information Authorization, and permit DHS to use public records and contact collateral sources for purposes of the eligibility determination.

If an applicant/recipient refuses to present information or verification required to reach a decision on an initial or continuing determination of eligibility and requests the agency not to obtain it, the agency would be unable to determine eligibility and would have no recourse but to deny or discontinue assistance.

In those instances where eligibility is based on the existence of the conditions of blindness or disability, additional medical information verifying these conditions is necessary. Appropriate forms and instructions are provided applicants for submitting this information.

0302.20

PERIOD OF ELIGIBILITY

REV:05/1999

When an individual is determined eligible for Medical Assistance, eligibility exists for the entire first month. Therefore, eligibility BEGINS on the first day of the month in which the individual is determined eligible. Medical Assistance ENDS when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given.

Medical Assistance benefits cease on the last day of the 10-day notice period when eligibility is determined to no longer exist.

However, in cases where the Flexible Test of Income policy is applied, eligibility is established on the day the excess income is absorbed; i.e., the day the medical service was provided.

Eligibility is for the balance of the six (6) month period.

The certification periods for MA beneficiaries are as follows:

- o Family, individual, and couple cases, with the exception of flexible test of income cases, are certified for MA up to a maximum of TWELVE (12) MONTHS. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.
- o Flexible Test of Income cases are certified for MA for the full SIX (6) MONTH (if eligible) or the BALANCE of the SIX (6) month period.
- o Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

Time limits for certification are established on the InRhodes Statement of Need Panel.

0302.25**CERTIFICATION OF ELIGIBILITY**

REV:01/2002

Written notice is sent to each applicant who files an application regarding his/her eligibility or ineligibility. When the applicant is found eligible, a NOTICE OF ELIGIBILITY is sent via InRhodes by the agency representative to notify the applicant of eligibility and the length of MA certification.

Eligible homeless individuals and families who are unable to provide a mailing address are advised to pick up computer-generated eligibility notices and MA cards at the District Office. the next business day. Homeless individuals and families who cannot provide mailing addresses are further advised of the need to come to the District Office one month prior to the certification end date to re-apply for MA. If a homeless recipient without a mailing address does not contact the District Office by the end of the certification period, staff must close the case on the end date of the certification period. Homeless individuals and families are certified for a maximum of three months.

0302.30**PAYMENT PROCESS**

REV:03/2002

Payment for medical care provided within the MA scope of services is made by the department's fiscal agent based on claims submitted by the provider of the medical service and supplies.

The fiscal agent utilizes the Medicaid Management Information System (MMIS) to review the claim and make payment.

Payment for services can also be made for unpaid medical services received in the three months prior to the month of application, provided the individual was eligible in that period. All bills are cleared for eligibility through the Division of Health Care Quality Financing and Purchasing, Center for Adult Health.

Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a Rite Care Health Plans or a Rite Share approved employer based group health plan are made in

accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

0302.30.05

MA as Payor of Last Resort

REV:06/1994

Medical insurance is not a bar to eligibility. However, all benefits for which the recipient is eligible must be paid before the Medical Assistance Program assumes responsibility for payment.

State law makes it illegal for insurance companies to exclude MA recipients from benefits, reinforcing the requirement of third-party liability (TPL) and that MA is the last payer.

The most common medical resources are Blue Cross/Blue Shield, Major Medical, Plan 100, Delta Dental, Harvard Community Health Plan of New England and Ocean State. Most employed people in Rhode Island are covered by one or a combination of these resources. Even in cases of separation, the family frequently continues to be covered by the absent parent's family coverage. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now pays claims for dependents of service personnel who are also MA recipients.

Older applicants, or those who are blind or disabled, are usually eligible for Federal Medicare. This is frequently supplemented by "Blue Cross 65" and/or a commercial accident and health insurance policy.

If, in the clearance of a claim, the Division of Medical Services discovers the possibility of a resource, a notice is sent to the Eligibility Technician requesting this be followed up with the recipient. A follow-up report regarding the results of the contact is submitted to the Division of Medical Services at Central Office.

IT IS MOST IMPORTANT THAT THE POSSIBILITY OF EVERY MEDICAL RESOURCE BE EXPLORED AND THAT ANY RESOURCE AVAILABLE BE NOTED ON THE INRHODES STATEMENT OF NEEDS FUNCTION. THE APPLICANT IS INSTRUCTED TO REPORT ANY NEWLY ACQUIRED RESOURCE.

0302.30.10

Direct Reimbursement to Recipients

REV:03/2002

Some individuals, while appealing a determination of Medical Assistance (MA) ineligibility, incur and pay for covered services. To correct the inequitable situation which results from an erroneous determination made by the Department, direct reimbursement is available to recipients in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of MA coverage is received by the Department within the time frame specified in Section 0110.20.
2. The original decision to deny or discontinue MA coverage is determined to be incorrect and, as such, is reversed on appeal by the Appeals Officer (hearing decision) or by the Regional Manager or Chief Supervisor/Supervisor (adjustment conference decision).

Reimbursement is only available if the original decision was incorrect. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

3. The recipient submits the following:
 - o a completed Application for Reimbursement form (MA 1R);
 - o a copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;
 - o proof of the date and amount of payment made to the provider by the recipient or a person legally responsible for the recipient. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the recipient or a person legally responsible for the recipient.
4. Payment for the medical service was made during the period between a denial of MA eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date

of MA termination, if later) and before the date of the written decision issued by the DHS Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date MA eligibility is approved, if earlier).

Example 1: An MA application is filed 9/1. A written notice of denial is issued on 10/1. On 10/15, a written request for appeal is received by the Department. The Appeal Office's decision, dated 12/1, finds that the original decision was incorrect and the individual is eligible for MA beginning in September. The agency representative approves MA eligibility on 12/2.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 (date of denial) and before 12/2 (date appeal decision was implemented.)

Example 2: Application is filed 9/1. A notice is issued on 9/15 denying MA for September due to excess income and approving MA beginning 10/1. The individual sends in a written request for an adjustment conference on 10/10. Upon review, the Chief Casework Supervisor finds that the original decision to deny MA was incorrect; the individual is eligible beginning September 1. MA eligibility is approved on 10/20.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 9/15 and on or before 9/30.

Example 3: A redetermination of continuing eligibility is completed and a notice of MA discontinuance is issued on 9/15. MA is discontinued effective 9/30. A written request for appeal is received on 10/12. In her written decision on 12/2, the Appeals Officer finds that the Department's original decision to discontinue MA was incorrect; MA must be reinstated beginning 10/1. MA is approved on 12/11.

To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 and before 12/11.

5. At the time the service was provided, the individual was eligible for MA and the service was within the covered scope of services, categorically needy or medically needy, allowed for the recipient.
6. A MA vendor payment would otherwise have been made at the time the service was provided, except that the provider does not have to be participating in the MA program.
6. The service was medically necessary when provided. However, prior approval requirements do not apply to such services.
7. Third party reimbursement is not available for the service.
8. Direct reimbursement may only be provided within the MA fee schedule in effect at the time the service in question was provided, even if the individual paid more than that amount.

PROCEDURE AND NOTIFICATION

The Department's notices of MA ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contains specific information about the availability of direct reimbursement if a written appeal is filed and the Department's initial decision is overturned as incorrect.

The written request for appeal is completed by the applicant or recipient and returned to the local DHS office. The agency representative, responsible for the case, completes the Department response. If upon receiving the request for hearing, the original decision is reversed and MA is reinstated, that information and the reason for reinstatement is noted in the Department response section of the hearing request form. The completed form is forwarded to the Appeals Office in accordance with policy in Section 0110.

If the original decision is reversed and MA is reinstated at any other time prior to the hearing, the Department representative sends written notification of the date of and reason for reinstatement to the Appeals Office.

The Appeals Office provides individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending. The form contains instruction for completion and return to the local DHS office.

The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that payment was made by the recipient or a person legally responsible for the recipient between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

If either the bill or proof of payment is not included with the Application form, the Department representative offers to assist the recipient in obtaining the required documentation, and sends an InRhodes SPEC reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the MA-1R. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of MA denial (or termination) and the date of MA acceptance (or reinstatement), the agency representative denies the request for reimbursement. A DHS 167A is completed and mailed, along with DHS form 121, to the recipient.

Otherwise, the agency representative forwards a referral form (DHS-48R), attaching the recipient's written request for reimbursement and all supporting documentation to the DHS Administrator in the Center for Adult Health, or his/her designee, for a decision on payment. The Center for Adult Health is responsible for providing the individual with written notification (DHS 40A or DHS 167A) of the agency's decision and rights to appeal.