MA-3245 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

I. OVERVIEW

A. The Division of Medical Assistance may contract with certain qualified medical providers to determine presumptive eligibility for pregnant women.

It is the provider's responsibility to determine presumptive eligibility and notify the county dss in the pregnant woman's county of residence. The county department of social services and its employees cannot determine presumptive eligibility.

B. The qualified provider who opts to determine presumptive eligibility must enroll with and be approved by DMA. Examples of qualified providers are community health centers, health departments, rural health clinics and other providers who receive maternal and child health funding. A list of enrolled Presumptive Eligibility Providers is updated regularly and issued by DMA Administrative Letter.

C. The qualified provider determines presumptive eligibility, by using the Presumptive Eligibility Determination Form (DMA-5032) for limited Medicaid benefits based on three eligibility criteria: pregnancy, income and living arrangement. The woman's pregnancy must be medically verified; her family income, based on her statement, must be equal to or below the 185% poverty income level; and the pregnant woman can not be an inmate of a public institution.

D. If the pregnant woman is determined presumptively eligible for Medicaid, the provider refers her to the county department of social services to apply for Medicaid. The pregnant woman is advised to apply for Medicaid no later than the last work day of the month following the month she is determined presumptively eligible.

E. If the pregnant woman fails to apply for Medicaid or Work First within this time period, she is eligible for limited Medicaid only through the last calendar day of the month following the month she is determined presumptively eligible.

F. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the county makes a determination on her application.

G. During the presumptive eligibility period, Medicaid will cover only ambulatory prenatal services provided by any Medicaid enrolled provider. This includes prescriptions.

H. Presumptive eligibility is limited to one presumptive eligibility period per pregnancy.

II. COUNTY PROCEDURES

A. On receipt of a Presumptive Eligibility Determination Form (DMA-5032) and transmittal form (DMA-5033):

1. Use the DMA-5183, Presumptive Eligibility Log, to log the case information as of date received.

2. Review the Presumptive Eligibility Determination Form to see that it is correctly completed. If the presumptive eligibility form is not signed and dated by both the pregnant woman and the provider, and/or if the medical verification of pregnancy is not signed:

a. Return the form to the provider for completion.

b. Document on the log that it has been returned to the provider for completion.

c. Take no further action until completed forms are returned to the county dss.

Note: Presumptive eligibility requires only that pregnancy be verified. The provider does not have to give the anticipated delivery date for presumptive eligibility.

3. If the pregnant woman's address indicates she is not a resident of your county:

a. Contact the provider on the day the presumptive eligibility forms are received.

b. Confirm the correct county of residence;

c. If the pregnant woman is not a resident of your county, return the presumptive eligibility forms to the provider.

4. The county dss can not refuse to authorize presumptive eligibility.

5. Retain the forms in a suspense file in accordance with county administrative procedures for retrieval when the pregnant woman comes in to apply or within the first five work days of the next calendar month if no application has been made.

6. If the pregnant woman already has a pending Work First or Medicaid application in any program, complete the bottom portion of the transmittal form indicating the status and return it to the provider within 5 work days. Keep a copy of the transmittal to send to the provider at disposition.

REISSUED 03/01/11– CHANGE NO. 03-11

(II.)

B. Authorizing Presumptive Eligibility

1. Presumptive coverage will be authorized and a Medicaid card issued.

2. Presumptive eligibility begins on the day the presumptive eligibility application is signed at the qualified medical provider.

3. Presumptive eligibility ends on the earliest of the following dates:

a. The last day of the month following the month presumptive eligibility was determined if the pregnant woman does not apply for Medicaid or Work First, or,

b. The day the county dss makes an eligibility determination if the pregnant woman does apply for Medicaid or Work First.

4. Process the presumptive application within the first five workdays of the month following the month presumptive eligibility is determined.

a. If no eligibility determination has been made, authorize presumptive eligibility beginning with the date the presumptive application was signed through the last day of that month.

b. Follow procedures in the EIS Users Manual to authorize presumptive eligibility and generate a Medicaid card.

c. A DSS-8108 is sent advising the pregnant woman of the dates authorized for presumptive eligibility. Advise her that it is her responsibility to notify the provider when she receives her Medicaid card.

d. Continue to review the presumptive application within the first five workdays of each month and authorize presumptive eligibility for the previous month until the presumptive eligibility period ends (refer to B.3.). Follow procedures in the EIS Users Manual.

C. If the pregnant woman does not apply for Medicaid or Work First by the last work day of the month following the month presumptive eligibility was determined:

1. Terminate presumptive eligibility following procedures in the EIS Users Manual.

2. Complete the bottom portion of the DMA-5033, transmittal form, and return it to the provider within 5 workdays. Include the pregnant woman's Individual ID and eligibility dates. Indicate on the form that the pregnant woman did not apply within the required timeframe.

REVISED 03/01/11 – CHANGE NO.03-11

(II.C.)

3. Send the pregnant woman the DSS-8108 advising her of the dates authorized for presumptive eligibility. Note that if the pregnant woman wants additional Medicaid coverage, she must come in to apply.

D. If the pregnant woman does apply for Medicaid or Work First by the last work day of the month following the month she was determined presumptively eligible:

1. The date of application is the date the DSS-8124 is signed.

2. Follow procedures in EIS Manual to enter the Medicaid or Work First application.

3. Complete the bottom portion of the transmittal form and return it to the provider within 5 work days indicating that she has applied and the status of the application (pending, approved, denied). Refer to II. E. and F.

E. If the pregnant woman applies and is determined ineligible for Medicaid:

1. Terminate presumptive eligibility effective the day the Medicaid application is denied. Follow procedures in the EIS Users Manual.

2. Send the DSS-8109 to the pregnant woman to notify her of the denial of her ongoing application.

3. Send a copy of the transmittal form to the provider within 5 workdays indicating that the application was denied. Note on the form the authorization dates for the presumptive period and the Medicaid ID number.

F. If the pregnant woman applies and is found eligible for Medicaid:

1. Follow procedures in the EIS Users Manual to authorize the case for ongoing coverage and retroactive coverage, if applicable, from the first day of the first month in which all eligibility factors are met.

2. Notify the pregnant woman of the approval of her application on the DSS-8108, including the dates of eligibility. Also, send the DMA-5076/DMA-5076S, Pregnancy Medical Home (PMH) handout.

3. Send a copy of the transmittal form to the provider within 5 workdays indicating that the application was approved. Note on the form the authorization dates and the Medicaid ID number.

REVISED 03/01/11 – CHANGE NO. 03-11

(II.)

G. If a NC Health Choice for Children recipient is presumptively eligible for Pregnant Women coverage:

1. Hold the presumptive eligibility determination up to the last work day of the month following the month in which presumptive eligibility is determined, or, until she applies for Medicaid,

2. If the pregnant woman applies for Medicaid and is eligible

a. Once eligibility is determined for Medicaid for Pregnant Women, send an adequate notice to terminate the NC Health Choice case.

b. Enter an administrative application for MPW. Date of application is the date the person applied for Presumptive Eligibility.

c. Approve the Medicaid for Pregnant Women the month after North Carolina Health Choice terminates. Follow the procedures in EIS for months already covered by NC Health Choice.

d. Contact Claims Analysis Unit in DMA at (919) 855-4045 if retroactive coverage of pregnancy related services are needed. A Claims Analyst will take the information necessary to provide coverage.

e. Send the DMA-5076/DMA-5076S, Pregnancy Medical Home (PMH) handout to her.

3. If the woman does not apply for Medicaid by the last workday of the month following the month presumptive eligibility is determined or is determined ineligible for Medicaid, she is eligible only for presumptive eligibility coverage. Call the Medicaid Eligibility Unit at DMA, (919) 855-4000 for instructions on entering the presumptive eligibility coverage.

4. If the presumptive eligibility period has not expired, County 1 transfers the presumptive eligibility application to County 2. County 1 notified the presumptive eligibility provider about the transfer.