COMBINED MEDICAID 104-1
Retroactive Medicaid

Supersedes: MA 104-3 (07/01/08); FMA 104-3 (01/01/08)

Reference: ARM 37.82.101, .204, .704, .904, .1111, 37.83.202; 42 CFR 435.914; 42; CFR 435.915

Overview: Medicaid coverage may be provided for up to three months immediately preceding the month of application or a new coverage request. The request can be made any time after initial application or new coverage request as long as the requested retro month is within the 365 days that the provider has to bill. For pregnancy-related coverage, retroactive Medicaid cannot be established prior to the month of conception.

For example: A household applies for Medicaid on 12/18/2016 and on 04/04/2017 requests retro coverage for 09/2016. Since 09/2016 is 3 months prior to the application month (12/2016) and the provider can still bill for a claim we can look at eligibility for that month. If the individual waited until 12/01/2017 to request retro for 09/2016 we would deny the request because the provider can no longer bill for 09/2016 services after 09/2017.

If Medicaid is already open on a case and a new Medicaid request is received for an individual not currently receiving Medicaid, the 3 retro months are from the coverage request date.

For example: Children in the household are open on Medicaid and mom requests coverage for herself on 03/14/2017, her retro months will be 12/2016, 01/2017, and 02/2017. Mom can request retro coverage any time after her initial request (03/2017) as long as the retro month is within the 365 days the provider has to bill.

Retroactive coverage is available to clients who would have been eligible for Medicaid at the time services were received if they had applied or requested coverage.

A system notice, either approving or denying retro coverage is sent any time retro coverage is requested. This information is included in the application approval/denial notice if retro is processed at the same time. If retro coverage is requested on the application (the applicant indicates that he/she has medical bills for any of the three months prior to application), the eligibility staff member must process that coverage request timely. If retro coverage is denied, a denial notice MUST be sent that provides the eligibility determination for all requested months.

For SSA (Social Security Administration) applicants, see Disability Determination Overview ABD 105-1.

FINANCIAL ELIGIBILITY:

Retroactive Medicaid coverage may be for any or all of the three Months immediately prior to the application or retro coverage request date, depending on when services were received. The client must meet all financial and non-financial eligibility requirements for each retro month.

The applicant does not need to be eligible in the application month to be eligible for retroactive Medicaid coverage. As long they were eligible in each of the retro months, coverage for those months is provided. Use actual income received and expenses incurred in the retroactive month or months when determining retroactive eligibility. For programs with a resource limit, if the applicant is resource eligible any day of the month, he/she is considered resource eligible for the entire month.

NOTE: Citizenship/qualified alien status and identity verification is required when processing retroactive Medicaid requests (if not already verified for ongoing Medicaid).

CONTINUED BENEFITS:

A retro month cannot be used to create an ongoing span if the client was not eligible in the application month or month after.

RETROACTIVE COVERAGE FOR SSI RECIPIENTS:

For SSA applicants, see Disability Determination Overview, ABD 105-1.

Effective Date: May 01, 2017