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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1735.1

GENERAL PROVISIONS FOR FEE-FOR-SERVICE MEDICAL ASSISTANCE

§17-1735.1-1	Purpose
§17-1735.1-2	An individual covered under fee-for-service medical assistance
§17-1735.1-3	Effective date of authorization
§§17-1735.1-4 to 17-1735.1-8	(Reserved)

Historical Note: This chapter is based substantially upon repealed chapter 17-1735. [Eff 08/01/94; am 07/20/95; am 02/10/97; am 07/06/99; am 02/16/02; am 05/10/03; 01/31/09; am 06/11/09; am 06/25/12; R 09/30/13]

§17-1735.1-1 Purpose. This chapter describes an individual covered under the State's fee-for-service component of the medical assistance program. The fee-for-service program is discussed in the following chapters: 17-1722, special medical assistance coverages and programs; 17-1736, provider provisions; 17-1737, scope and contents of the fee-for-service medical assistance program; 17-1738, targeted case management services; 17-1739, authorization, payment, and claims in the fee-for-service medical assistance program; 17-1740.1, reimbursement of federally qualified health centers and rural health clinics; and 17-1741, utilization control.
[Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

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§17-1735.1-2 An individual covered under fee-for-service medical assistance. (a) An individual eligible for fee-for-service coverage under the medical assistance program includes, but is not limited to:

- (1) A child in receipt of foster care, kinship guardianship or adoption assistance, under age twenty-one who is a resident of the State, and placed in another state as described in chapter 17-1715;
- (2) A non-citizen ineligible for Medicaid assistance who receives emergency medical services as described in chapter 17-1723.1;
- (3) An individual who enters the State of Hawaii Organ and Tissue Transplant (SHOTT) program as described in chapter 17-1737;
- (4) An incarcerated individual who is admitted as an inpatient in a medical institution not on the grounds of the incarceration facility;
- (5) An individual who receives a determination of eligibility on or after the start date of a new health plan contract period that is retroactive to a date prior to the start of the new health plan contract period with incurred services during the period from the effective date of coverage up to the start date of the new health plan contract period;
- (6) A medically needy individual who is not aged, blind or disabled as described in chapter 17-1730.1; or
- (7) An individual who is eligible for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled and Working Individuals (QDWI), or Qualifying Individuals (QI) program described in chapter 17-1722.

(b) While enrolled in a participating health plan, an individual is excluded from the fee-for-service program, except for the following additional services that may be provided on a fee-for-service basis, subject to approval by the department:

- (1) Services provided through the Medicaid waiver program for an individual with developmental disabilities or intellectual disabilities (DD-ID);

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- (2) ICF-ID institutional services;
- (3) School-based health related services;
- (4) Early intervention program services;
- (5) Specialized behavioral health services; and
- (6) Dental services as described in section 17-1737-75.

(c) The department shall determine on a case-by-case basis, whether an individual enrolled in a managed care program may have additional services covered on a fee-for-service basis. [Eff 09/30/13] (Auth: HRS §§88-4, 346-14; 42 C.F.R. §§430.25, 435.1009, 435.1010, 440.150; 42 U.S.C.§1396d(a)(28)(A)) (Imp: HRS §§88-4, 346-14; 42 C.F.R. §§430.25, 435.1009, 435.1010, 440.150; 42 U.S.C.§1396d(a)(28)(A))

§17-1735.1-3 Effective date of authorization.

(a) The effective date for payments to be made for covered services under the fee-for-service program for an individual described in section 17-1735.1-2 shall be:

- (1) The date the application is received by the department as described in chapter 17-1711.1;
- (2) Any date specified by the individual on which appropriate Medicaid eligible services were incurred and is no earlier than the first day of the third month prior to the month the application is received by the department for an individual applying for the coverage of long-term care services, or the immediate ten calendar days prior to the date the application is received by the department for all other individuals; or
- (3) The date when all eligibility requirements are met by the applicant.

(b) An applicant's eligibility for medical assistance within a retroactive period is established when:

- (1) A submittal of a signed application is received from an applicant, an individual or department's representative on behalf of a deceased individual.
- (2) Part or all of the individual's medical bills remain unpaid;

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- (3) The expenses incurred by the individual were for medical care and services within the scope of services covered under the fee-for-service program as described in chapter 17-1737 and authorization for medically necessary services approved as described in chapter 17-1739.1; and
- (4) The care and services were provided by an eligible participating provider.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14; 42 C.F.R. §§435.914, 440.10, 440.20, 440.30, 440.40, 440.50, 440.60, 440.70, 440.80, 440.90, 440.100, 440.110, 440.120, 440.130, 440.140, 440.150, 440.155, 440.160, 440.165, 440.166, 440.167, 440.168, 440.169, 440.170, 440.180, 440.181, 440.185)

§§17-1735.1-4 to 17-1735.1-8 (Reserved).