## Medical Indemnity Fund FAQs

This guidance is provided for informational purposes. Regulations have been issued by the Commissioner of Health. In the unlikely case of a conflict between this FAQ and any regulations issued by the Commissioner of Health, the regulations would prevail.

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### General Questions

**What is the Medical Indemnity Fund and why was it created?**

Chapter 59 of the Laws of 2011 amended Article 29-D of the Public Health Law to create the Medical Indemnity Fund ("Fund"). The Fund is designed to provide a funding source for future health care costs of plaintiffs in medical malpractice actions who have suffered birth-related neurological injuries as the result of medical malpractice during a delivery admission, and are plaintiffs as defined in the law. The purpose of the Fund is two-fold: 1) to pay or reimburse certain costs necessary to meet the health care needs of a plaintiff throughout his or her lifetime; and 2) to lower the expenses associated with medical malpractice litigation throughout the health care system.

**What is a "birth-related neurological injury" for the purpose of the Fund?**

For the purpose of the Fund, a "birth-related neurological injury" is an injury to the brain or spinal cord as the result of a deprivation of oxygen or mechanical injury that occurred in the course of labor, delivery or resuscitation, or by the provision or non-provision of other medical services during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability.

**What costs will the Fund pay or reimburse?**

The Fund will pay or reimburse "qualifying health care costs" necessary to meet the health care needs of a plaintiff as determined by a physician, physician assistant or nurse practitioner, and as otherwise defined by the Commissioner of Health in regulation. Examples of qualifying health care costs include:

- medical treatment
- hospital-based care
- surgical care

- nursing care
- dental care
- rehabilitative care
- custodial care
- durable medical equipment
- certain home modifications
- assistive technology
- certain vehicle modifications
- prescription and non-prescription medications
- other health care costs for services rendered to, and supplies utilized by, enrollees.

**What happens if the plaintiff has health insurance?**

Any health insurance, excluding Medicaid and Medicare, available to a plaintiff must be utilized for each claim before the Fund will become a payer. Amounts paid for copayments and deductibles may be reimbursable by the Fund, however health insurance premiums are not.

**What happens if the plaintiff is also enrolled in an Individualized Education Program, Preschool Supportive Health Services Program, Early Intervention Program?**

Qualifying health care costs paid by the Fund cannot lawfully include any services or equipment potentially available to the enrollee under an Individualized Education Program, Preschool Supportive Health Services Program, Early Intervention Program (or equivalent program in another country), unless the enrollee's parent or guardian can demonstrate that he or she made a reasonable effort to obtain the services or equipment through such a program which was denied.

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## Enrollment

**Who can apply for enrollment into the Fund?**

A plaintiff, anyone authorized to act on the plaintiff’s behalf or a defendant in the medical malpractice action that results in a court-approved settlement or judgment may apply to enroll the plaintiff into the Fund.

**What documentation is required as part of the application?**

A party seeking to enroll a plaintiff must submit the following:

- a completed and accurate Application Form, that includes the names, addresses and phone numbers of all providers providing services to the applicant;
- an Authorization for Release and Use of Medical Information Form signed by a person authorized to act on the plaintiff's behalf;
- a certified copy of the court-approved settlement or judgment, including all documents and/or exhibits referenced in the settlement or judgment;
- summary provided by the treating physician regarding the specific nature and degree of the applicant's birth-related neurological injury or injuries, including diagnoses and impact on the applicant's activities of daily living and instrumental activities of daily living, for example: a copy of the long-term plan of care, etc.
- documentation of all other present sources of health care covered or reimbursement, including commercial insurance and/or government programs; and,
- any other information determined by the Fund Administrator to be necessary.

**Will the Fund Administrator provide assistance to help with the application process?**

The Fund Administrator will provide assistance with the application process.

**What information must be included in the court-approved settlement agreement or judgment in order for a plaintiff to be eligible for enrollment into the Fund?**

Every settlement agreement that provides for the payment of future medical expenses for the plaintiff or claimant must provide that in the event the administrator of the fund determines that the plaintiff or claimant is a qualified plaintiff all payments for future medical expenses will be paid in accordance with Title 4 of Article 29-D of the Public Health Law, in lieu of that portion of the settlement agreement that provides for payment of such expenses. When a settlement agreement does not so provide, the court shall direct the modification of the agreement to include such term as a condition of court approval.

With respect to a judgment, as a condition of enrollment, the judgment must state that, in the event the administrator of the fund determines that the plaintiff or claimant is a

qualified plaintiff, in lieu of that portion of the award that provides for payment of such expenses, the future medical expenses of the plaintiff shall be paid out of the Fund in accordance with Title 4 of Article 29-D of the Public Health Law. The Public Health Law sets out a procedure by which any party in an action of medical malpractice resulting in a birth-related neurological injury may petition the court for the court to add such language in the judgment.

**How long must a plaintiff wait to be enrolled once an application to the Fund has been submitted?**

A plaintiff will be enrolled within five (5) business days following the submission of all documentation required as part of the application for enrollment.

**What happens to enrollees in the Fund if enrollment is suspended?**

Once enrolled, a plaintiff will remain in the Fund for his or her lifetime and will not be impacted by a suspension in enrollment. Such a suspension would only happen if the Fund's estimated liabilities – the sum of the eligible costs for all enrollees in a given year – equal or exceed 80 percent of its assets. If this occurs, then new enrollment into the Fund will be suspended until either an adequate deposit of funds is made, or an actuarial analysis determines that the Fund's estimated liabilities are less than 80 percent of its assets and the Fund Administrator reinstates enrollment. The Fund Administrator will provide public notice upon any suspension or reinstatement of enrollment.

**Will the Fund Administrator provide assistance to help with the claims filing process?**

Yes, the Fund Administrator will provide assistance.

**Must plaintiffs be current or past New York residents?**

No. Eligibility for or continued enrollment in the Fund is not dependent on the current or past residency of an individual.

**How are qualifying health care costs paid or reimbursed?**

Regulations have been developed by the Commissioner of Health to provide for a claims submission and payment process. In most instances the provider will submit claims directly to the Fund Administrator and be paid directly by the Fund. There is also a process for reimbursement in instances where out-of-pocket costs are incurred by the enrollee.

**What health care costs require prior approval?**

The Department of Health regulations require certain services to be approved in advance (prior approval). They include non-routine services such as environmental modifications, vehicle modifications, assistive technology, private duty nursing, hearing aids, custom made durable medical equipment, specialty drugs, experimental treatments, travel expenses for medical care, myo-electric limbs and respite care exceeding 1080 hours in a calendar year.

**Is there any administrative review available if there is a denial of a claim?**

Yes. The regulations developed by the Commissioner of Health establish an administrative review process. A request for review form must be submitted within 30 days of receipt of a denial. The enrollee may request a document-based review or a hearing, to be conducted by a hearing officer.

**How long does it take for the Fund Administrator to process claims?**

Claims must be submitted to the Public Consulting Group within 90 days of the date of service. Claims for qualifying health care costs will be paid within 45 days of receipt of an acceptable claims form. A request for permission to submit a claim later than 90 days from the date of service may be granted by the Fund Administrator upon a showing of good cause for the delay.

**Can non-domestic providers be reimbursed through the Fund?**

Yes, non-domestic providers are eligible for reimbursement through the Fund, and the same qualifications for reimbursable health care services for domestic providers pertain to non-domestic providers. Qualifying health care services performed by non-domestic

providers are paid as billed. Claims will be paid at the USD exchange rate determined for the date of service.

In lieu of an HCFA 1500 or UB 04 Forms providers should submit a detailed invoice containing descriptions of service and itemized costs for each service.

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## Operations of the Fund

### Will the Fund Administrator provide assistance to help with the claims filing process?

Yes, the Fund Administrator will provide assistance.

### How do I get more information?

Additional updates and updated responses to frequently asked questions will be posted here. We encourage you and your family to periodically review these pages over the upcoming weeks to review additional program announcements.

### How can I get in contact with the MIF fund administrator team?

Contact the PCG team with questions about enrollment, authorizations and case management.

- **PHONE**
  (855) NYMIF33
  (855) 696-4333
- **MAIL**
  P.O. Box 7315 Albany, N.Y. 12224
- **EMAIL**
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