

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT**

**PREFERRED PHYSICIANS AND CHILDREN PROGRAM
(PPAC)**

NURSE PRACTITIONER APPLICATION

Medicaid Preferred Physicians and Children Program

Beginning April 1, 1991, the New York State Department of Health invites interested nurse practitioners meeting certain eligibility and practice requirements to apply to participate in the Medicaid Preferred Physicians And Children Program, hereinafter referred to as PPAC.

Reimbursement

Nurse practitioners participating in PPAC receive increased Medicaid fees for visits provided to Medicaid recipients under 21 years of age. The fee structure for all visits incorporates a regional adjustment for upstate and downstate.

The upstate reimbursement for office visits is \$33.63; the figure for downstate is \$39.64. The current logic for visits in settings other than office is that of an enhanced fee: \$30 upstate and \$36 downstate.

The counties considered downstate for this program are Bronx, Kings, Queens, New York, Richmond, Nassau, Suffolk, Westchester, Putnam, and Rockland.

Billing

When billing for care to Medicaid recipients under 21 years of age, for well child care services furnished in an office setting use the CPT-4 Preventive Medicine Services codes 99381-99385 and 99391-99395. For Newborn care services use 99431, 99433 or 99435.

For all other services provided in a practitioner's office or other ambulatory setting, use the Evaluation and Management procedure codes 99201-99205, and 99211-99215. Report the place of service code that represents the location where the services was rendered in claim field 24B, Place of Service. The maximum reimbursable amount for these codes is dependent on the Place of Service reported. The PPAC Section of the Nurse Practitioner Manual defines these codes.

The ancillary services and procedures performed during any visit must be claimed through the use of customary Medicaid procedure codes; these claims will be reimbursed at customary Medicaid fee levels.

Eligibility and Practice Requirements

The PPAC eligibility and practice requirements for the nurse practitioner appear on pages **3 and 4** of the instructions.

Application

Nurse practitioners may apply to participate in PPAC by completion of the *Application to Participate in the PPAC Program*. This form must be completed by every nurse practitioner applying to participate in PPAC: The nurse practitioner already enrolled as a Medicaid provider, the nurse practitioner applying to enroll as a Medicaid provider **and** PPAC participant, and the nurse practitioner whose enrollment in Medicaid has lapsed and he/she wishes to enroll in Medicaid and participate in PPAC.

If the forms necessary to enroll in Medicaid and/or apply to participate in PPAC are not included with this letter, they may be obtained by written request to Computer Sciences Corporation, P.O. Box 4610, Rensselaer, NY 12144 or by downloading forms from the Internet at www.emedny.org.

Notification

A letter of decision regarding the nurse practitioner's application will be sent by this Department to the applicant's correspondence address as listed on the MMIS Provider File. If application for the Medicaid enrollment and PPAC participation are made at the same time, the letter of decision regarding the Medicaid application will be sent first followed by a later date by the letter of decision regarding PPAC participation.

Questions

Program experience has shown that practitioners frequently ask the following questions:

1. How long does it take for the PPAC application to be processed?

Assuming that the documentation in the application was completed and no additional information was necessary, the application process takes a minimum of four weeks from the date the application was mailed to the date of receipt of the letter of decision from the Department of Health.

2. When may PPAC claims be submitted to Medicaid?

PPAC claims may be submitted after receipt of the letter of decision from this Department. The letter will include the earliest date of service for which you may claim PPAC codes.

3. How are clinic visits to be billed under PPAC?

PPAC is a program for office-based practitioners. Services provided in hospital clinics or in diagnostic and treatment centers, where a clinic claim is also generated for a recipient's visit, are not to be claimed with PPAC codes. Services provided in an emergency room, pursuant to a contractual agreement with the hospital, may not be claimed with PPAC codes.

Be certain NOT to send in this cover letter with your application. Keep it for its descriptive information and for the telephone numbers noted.

To inquire about matters of specialty, hospital admitting privilege or required documentation, call 1-800-343-9000.

Nurse Practitioner Eligibility and Practice Requirements

- I. The qualified nurse practitioner (primary care) will:
 - Have a collaborative agreement with a physician who has an agreement with the Medicaid program to participate in PPAC as a primary care physician.
 - Provide 24-hour telephone coverage for consultation. This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner, or physician's assistant to respond to patients. This requirement cannot be met by a recording referring patients to emergency rooms.
 - Provide medical care coordination. Medical care coordination will include at a minimum the scheduling of elective hospital admissions; assistance with emergency admissions; management of and/or participation in hospital care and discharge planning; scheduling of referral appointments with written referral as necessary and with request for follow-up report; and scheduling for necessary ancillary services.
 - Provide periodic health assessment examination in accordance with the standards of the Medicaid Child/Teen Health Program.
 - Be a provider in good standing if enrolled in the Medicaid program at time of application to PPAC.
 - Sign an agreement with the Medicaid program, such agreement to be subject to cancellation with 30-day notice by either party.

II. The qualified nurse practitioner (non-primary care) will:

- Have a collaborative agreement with a physician who has an agreement with the Medicaid program to participate in PPAC as a qualified non-primary care specialist physician.
- Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultation visit.
- Notify the primary care physician when scheduling hospital admission.
- Be a provider in good standing if enrolled in the Medicaid program at time of application to PPAC.
- Sign an agreement with the Medicaid program, such agreement to be subject to cancellation with 30-day notice by either party.

ATTENTION

**MEDICAID PREFERRED PHYSICIANS AND CHILDREN PROGRAM
(PPAC)**

**NURSE PRACTITIONER APPLICANTS TO PPAC
MUST COMPLETE THIS APPLICATION TO ENROLL IN THE PPAC PROGRAM.**

Instructions:

1. Type or print the information in the space provided.
2. Submit a copy of your current RN license registration and Nurse Practitioner Certification.
3. Attach required documentation.
4. Sign and date ASSURANCES.
5. Submit completed application and required documentation to:
Computer Sciences Corporation
P.O. Box 4610
Rensselaer, NY 12144

SECTION A - IDENTIFYING INFORMATION

1. LAST NAME: _____
FIRST NAME: _____ MIDDLE INITIAL _____
2. LICENSE NUMBER: _____ STATE: _____
3. PLEASE COMPLETE THIS QUESTION IF YOU ARE AN ENROLLED MEDICAID PROVIDER.
NATIONAL PROVIDER IDENTIFIER (NPI): _____ MMIS _____

SECTION B - PRACTICE INFORMATION

4. List below the name and NPI number of the PPAC physician(s) with whom you have a collaborative agreement(s):

NAME	NPI/MMIS#
_____	_____/_____
_____	_____/_____
_____	_____/_____

5. List below the addresses of all the places where you have provided services to Medicaid Recipients:

ATTACH ADDITIONAL SHEETS IF NECESSARY

SECTION C - ASSURANCES

6. I recognize that I continue to be bound by the rights, obligations, duties or interests accrued, incurred or conferred as a result of my enrollment in the New York State Medicaid program.
7. As a preferred primary care nurse practitioner I assure the provision of comprehensive medical care services to Medicaid patients below the age of twenty-one years, in accordance with generally accepted standards of medical practice and, for well visits, in accordance with the requirements of the Child/Teen Health Plan.
8. As a preferred primary care nurse practitioner I agree to provide medical care coordination as part of my care, such medical care coordination to include at a minimum: the scheduling of elective hospital admissions; where possible, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning; scheduling of referral appointments with written referral as necessary and with request for follow-up report; scheduling for necessary ancillary services; telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care; and the maintenance of a complete medical record to include but not be limited to notation of referrals and hospitalizations, and copies of test results and reports.
9. I assure that patients with Medicaid will be free to choose their primary care physician or nurse practitioner and will be free to choose, from among qualified providers, the specialist to whom they will be referred.
10. As a primary care nurse practitioner I assure that I will maintain twenty-four hour telephone coverage, which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement cannot be met by a recording referring patients to the emergency room.
11. I assure that I will request as necessary from the NYS Department of Health, and display conspicuously on my premises, designated informational materials that serve to inform the public regarding Medicaid eligibility and services for persons under twenty-one years of age and for pregnant women.
12. I assure that I will notify the NYS Department of Health within thirty (30) days of circumstances resulting in my **ineligibility** to continue this agreement and/or my **inability** to perform the activities and services required under this agreement.
13. I recognize that the State may determine new visit types and rates during the term of this agreement and that the new visit types and rates may supersede those available at the time of this agreement.
14. I assure that I will abide by all reasonable policies, procedures, and instructions provided by the State to implement and execute the Preferred Physicians and Children Program, and will bill Medicaid in accordance with the reimbursement methodology established by the State.
15. I recognize that the New York State Department of Health may cancel my participation in the Preferred Physicians and Children Program at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the Preferred Physicians and Children Program will include but not be limited to my failure to comply with these assurances, including but not limited to failure to accurately bill Medicaid under the reimbursement methodology established.
16. I recognize that I may request cancellation of my participation in the Preferred Physician and Children Program when there are extenuating circumstances, giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will include a description of the basis for the request. I agree to continue to provide and/or arrange services for currently served patients up to the date of termination. I assure that I will assist patients to maintain continuity of care; provide them with information to assist them to transfer their care; and make timely transfer of their records upon request.

17. I accept that upon my designation by the New York State Department of Health to participate in the Preferred Physician and Children Program, these Assurances will be effective and may continue in effect thereafter with the consent of both parties and so long as Federal financial participation is available. I accept that services rendered prior to my enrollment will not be eligible for reimbursement through the Preferred Physician and Children Program.

18. PRINT NAME: _____

19. SIGNATURE: _____

20. DATE: _____

SECTION D - COLLABORATING PPAC PHYSICIAN CERTIFICATION

This information must be completed by at least one PPAC physician with whom you have a collaborative agreement.

21. PHYSICIAN'S SIGNATURE: _____

22. NATIONAL PROVIDER IDENTIFIER: _____ MMIS # _____

23. DATE: _____