

**NEW YORK STATE
MEDICAID PROGRAM**

**NURSE PRACTITIONER MANUAL
POLICY GUIDELINES**

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Section I - Requirements for Participation in Medicaid

Qualifications

A nurse practitioner must be licensed and currently registered as a registered professional nurse in New York State (NYS) and certified as a nurse practitioner by the NYS Department of Education (NYSED) in order to participate in the NYS Medicaid Program.

To be so certified a nurse practitioner:

- must have satisfactorily completed educational preparation for the provision of services in a program registered by the NYSED or in a program determined by the NYSED to be equivalent;
- must submit evidence of current certification by a national certifying body recognized by the NYSED, or
- meet alternative criteria as established by the Commissioner of Education.

Services rendered by a nurse practitioner must be in accordance with Sections 6902 and 6910 of the **NYS Education Law**. License requirements are established by the NYSED, and can be found at:

<http://www.op.nysed.gov/nurse.htm>.

Collaborative Agreements and Practice Protocols

The practice of a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures. A nurse practitioner must have a collaborative agreement and practice protocols with a licensed physician in accordance with the requirements of the NYSED.

A physician may have collaborative agreements with no more than four nurse practitioners who are not located on the same physical premises as the physician.

The collaborating physician must be enrolled in the Medicaid Program and not have been excluded from participation in the Medicaid or Medicare Program.

If the collaborating physician becomes excluded from Medicaid, the collaborative agreement is considered terminated for purposes of the Medicaid Program.

When a collaborative agreement is terminated with the physician, the nurse practitioner and the collaborating physician must notify the Medicaid Program of the effective date

of termination. Payment will not be made for services provided to Medicaid eligible clients beyond that date.

A new collaborative agreement with another physician must be on file with the NYSED and the Medicaid Program must be notified of the effective date for provision of services to Medicaid clients to resume.

Each practice agreement must provide for patient record review by the collaborating physician. The review must occur in a timely fashion but at least every three months. The physician's review of patient records is not a billable service under Medicaid. The nurse practitioner must make the collaborative agreement, practice protocols and evidence of record review available for Medicaid audit purposes.

The names of the nurse practitioner and of the collaborating physician must be clearly posted in the practice setting of the nurse practitioner. The collaborative agreement and practice protocol must be maintained in the private office of the nurse practitioner.

Medicaid Enrollment

A nurse practitioner must be enrolled with the NYS Department of Health (DOH), Medicaid Program, in order to receive reimbursement for services provided to a Medicaid eligible client.

The nurse practitioner must submit the name, license number, and the Medicaid Identification Number of the collaborating physician with the nurse practitioner's Medicaid enrollment application.

*The Medicaid Program must be notified **immediately** of any changes in the parties to collaborative agreements.*

Record Keeping Requirements

Nurse practitioners are required to maintain complete, legible records in English for each client treated.

NYS Medicaid regulations require medical records to include following, at a minimum:

- The full name, address and Medicaid client identification number of each client examined and/or treated in the office for which a bill is submitted;
- The date of each client's visit;
- The client's chief complaint or reason for each visit;

- The client's pertinent medical history as appropriate to each visit, and findings obtained from any physical examination conducted that day;
- Any diagnostic impressions made for each visit;
- A recording of any progress of a client, including client's response to treatment;
- A notation of all medication dispensed, administered or prescribed, with the precise dosage and drug regimen for each medication dispensed or prescribed;
- A description of any X-rays, laboratory tests, electrocardiograms or other diagnostic tests ordered or performed, and a notation of the results thereof;
- A notation as to any referral for consultation to another provider or practitioner, a statement as to the reason for, and the results of such consultations;
- A statement as to whether or not the client is expected to return for further treatment, the treatment planned, and the time frames for return appointments;
- A chart entry giving the medical necessity for any ancillary diagnostic procedure;
- All other books, records and other documents necessary to fully disclose the extent of the care, services and supplies provided.

For auditing purposes, records on clients must be maintained and be available to authorized Medicaid officials for six years following the date of payment.

Child/Teen Health Program (CTHP) examination and record-keeping requirements may be found in the **EPSDT/CTHP Manual for Child Health Plus A (Medicaid) Provider Manual**, located online at:

<http://www.emedny.org/ProviderManuals/EPsDTCTHP/index.html>.

Child Abuse or Maltreatment Reporting Requirements

Nurse Practitioners are required to report child abuse or maltreatment to the State Central Registry when they have reasonable cause to suspect:

- That a child coming before them in their professional or official capacity is an abused or maltreated child; or
- When the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and so states from personal knowledge facts, conditions or circumstance which, if correct, would render this child abused or maltreated.

Reports by mandated reporters are made to the State Central Register by calling the police and/or the mandated reporter hotline at:

(800) 635-1522.

Hospitals may make reports by fax at:

(800) 635-1554.

Mandated reporters must file a signed, written report (DSS-2221A). Forms and further information regarding the identification and reporting of suspected child abuse and maltreatment are available on the NYS Office of Children and Family Services (OCFS) website:

www.ocfs.state.ny.us/main/cps.

For a *Guide to New York's Child Protective Services System*, check the NYS Assembly website at www.assembly.state.ny.us/comm and select Children and Families/Updates.

Section II - Nurse Practitioner Services

Obstetrical Services

Obstetrical care includes prenatal care in a nurse practitioner's office or dispensary, postpartum care and, in addition, care for any complications that arise in the course of pregnancy and/or the puerperium.

The following standards and guidelines are considered to be part of normal obstetrical care.

Antepartum Care

Under normal circumstances the patient should be seen by the nurse practitioner every 4 weeks for the first 28 weeks of pregnancy, then every 2 weeks until the 36th week and weekly thereafter, when this is feasible.

As part of complete antepartum care, provision of the following laboratory and other diagnostic procedures is encouraged:

- Papanicolaou smear,
- complete blood count,
- complete urine analysis,
- serologic examination for syphilis and hepatitis,
- chest X-ray with proper shielding of the abdomen, and
- blood grouping and Rh determination with serial antibody titers, where indicated.

Postpartum Care

Upon discharge from the hospital, the patient should be seen for a postpartum physical exam at 3 to 6 weeks and again in 3 to 6 months.

A Papanicolaou smear should be obtained during the postpartum period at one of the visits.

Other Medical Care

Consultation with specialists in other branches of medicine should be freely sought without delay when the condition of the patient requires such care.

Expanded Eligibility and Services for Pregnant Women and Infants

Income eligibility levels have been expanded for pregnant women and infants up to age one. Many pregnant women, who were previously not eligible, may now receive medical assistance.

To encourage early prenatal care, Medicaid application procedures for pregnant women have been simplified. Women who are deemed eligible for Medicaid by their LDSS are guaranteed eligibility *regardless of income changes*, up until the end of the month in with the sixtieth day after the end of the pregnancy occurs.

Prenatal Care Assistance Programs

Prenatal Care Assistance Program (PCAP) providers, certified by DOH, provide a comprehensive package of prenatal care services through hospitals and clinics. PCAP providers may provide prenatal services either directly or through subcontract with qualified private physicians or agencies.

The PCAP providers are reimbursed for all prenatal and postpartum visits, laboratory and ultrasound (sonogram) procedures.

For more information, patients should be instructed to call the **Healthy Baby Hotline** toll-free at:

(800) 522-5006.

Medicaid Obstetrical and Maternal Services Program

Nurse practitioners who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Services (MOMS) program and receive increased fees for obstetrical care.

A key component of the MOMS program is the requirement that obstetrical providers refer women to approved health supportive service providers such as hospital and free-standing clinics and home health and visiting nurse agencies for services such as:

- health education,
- psychosocial assessment and counseling,
- nutrition education,
- WIC, and
- help with transportation and day-care.

The health supportive service provider will also assist women with the Medicaid application process. Reimbursement for health supportive services is on a separate schedule and is not included in fees for obstetrical care.

For enrollment information as a health supportive service provider, please write to:

New York State Department of Health
Perinatal Health Unit
Empire State Plaza
Corning Tower Room 780
Albany, New York 12237.

For nurse practitioner enrollment information call:

(800) 343-9000 select option 5.

Family Planning

Family planning services are those health services which enable individuals, including minors who may be sexually active, to plan their families in accordance with their wishes, including the number of children and age differential, and to prevent or reduce the incidence of unwanted pregnancies.

Medicaid does not cover treatment of infertility.

Medical family planning services include:

- diagnosis,
- treatment and related counseling,
- insertion of Norplant,
- as well as drugs and supplies prescribed by a nurse practitioner.

Examples of family planning services are:

- visits associated with a contraceptive method,
- counseling,
- insertion of Norplant, and
- completion of the required consent form for sterilization.

Family planning services do not include hysterectomy procedures or sterilization of individuals less than 21 years of age.

Patient Eligibility

All Medicaid-eligible patients of childbearing age, who desire family planning services without regard to marital status or parenthood, are eligible for such services *with the exception of sterilization*.

Family planning services, including the dispensing of both prescription and non-prescription contraceptives *but excluding sterilization*, may be given to minors who wish them without parental consent.

Medicaid eligible minors seeking family planning services may not have a Common Benefit Identification Card in their possession. *To verify eligibility, the nurse practitioner or his/her staff should obtain birth date, sex and social security number of the patient, or as much of this information as possible before contacting the DOH at:*

(518) 472-1550.

*If sufficient information is provided,
Department staff will verify the eligibility of the individual for Medicaid.*

Medicaid clients enrolled in managed care plans (identified on MEVS as "PCP" or "Managed Care Coordinator"), may obtain HIV blood testing and pre- and post-test counseling when performed as a family planning encounter from the managed care plan or from any appropriate Medicaid-enrolled Provider without a referral from the managed care plan.

Services provided for HIV treatment may only be obtained from the managed care plan. Additionally, HIV testing and counseling not performed as a family planning encounter may only be obtained from the managed care plan.

Patient Rights

Patients are to be kept free from coercion or mental pressure to use family planning services.

In addition, patients are free to choose their medical provider of services and the method of family planning to be used.

Standards for Providers

Family planning services can be provided by a licensed private physician, a licensed nurse practitioner, clinic, or hospital, which complies with all applicable provisions of law.

In addition, services are available through designated Family Planning Service Programs that meet specific DOH requirements for such Programs.

Sterilizations

Medical family planning services include sterilizations.

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

The requirements are provided here to inform nurse practitioners who may be involved in obtaining the patient's consent. Medicaid reimbursement is available for sterilization only if the following requirements are met:

Sterilization Requirements

In addition to provision of this information at the initial counseling session, the physician who performs the sterilization must discuss the information below with the client shortly before the procedure, usually during the pre-operative examination.

Informed Consent

The person who obtains consent for the sterilization procedure must offer to answer any questions the individual may have concerning the procedure, provide a copy of the *Medicaid Sterilization Consent Form (DSS-3134)* and **provide verbally all of the following information or advice to the individual to be sterilized:**

- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

- A full description of the benefits or advantages that may be expected as a result of the sterilization;
- Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified below under "Waiver of the 30-Day Waiting Period."

Waiting Period

The client to be sterilized must have voluntarily given informed consent not less than 30 days nor more than 180 days prior to sterilization.

When computing the number of days in the waiting period, the day the client signs the form is not to be included.

Waiver of the 30-Day Waiting Period

The only exceptions to the 30-day waiting period are in the cases of:

- premature delivery when the sterilization was scheduled for the expected delivery date or
- emergency abdominal surgery.

In both cases, informed consent must have been given at least 30 days before the intended date of sterilization.

Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, as long as 72 hours have passed between the original signing of the informed consent and the sterilization procedure.

Minimum Age

The client to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.

Mental Competence

The client must not be a mentally incompetent individual.

For the purpose of this restriction, "mentally incompetent individual" refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purposes unless the individual has

been declared competent for purposes which include the ability to consent to sterilization.

Institutionalized Individual

The client to be sterilized must not be an institutionalized individual.

For the purposes of this restriction, "institutionalized individual" refers to an individual who is either:

- *involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or*
- *confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.*

Restrictions on Circumstances in Which Consent is Obtained

Informed consent may not be obtained while the client to be sterilized is:

- in labor or childbirth;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the client's state of awareness.

Foreign Languages

An interpreter must be provided if the client to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

Handicapped Persons

Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind or otherwise handicapped individuals.

Presence of Witness

The presence of a witness is optional when informed consent is obtained, except in New York City when the presence of a witness of the client's choice is mandated by New York City Local Law No. 37 of 1977.

Reaffirmation Statement (NYC Only)

A statement signed by the client upon admission for sterilization, acknowledging again the consequences of sterilization and his/her desire to be sterilized, is mandatory within the jurisdiction of New York City.

Sterilization Consent Form

A copy of the *New York State Sterilization Consent Form (DSS-3134)* must be given to the client to be sterilized and completed copies must be submitted with all surgeon, anesthesiologist and facility claims for sterilizations.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed DSS-3134 in their files. A copy of the form and instructions for completion are included in the Billing Guidelines section of this Manual.

To obtain the DSS-3134 form, in English and/or Spanish, write to:

New York State Department of Health
Office of Medicaid Management
The Governor Nelson A. Rockefeller Empire State Plaza
Corning Tower, Room 2029
Albany, New York 12237
Attn: Mr. Margiasso

New York City

New York City Local Law No. 37 of 1977 establishes guidelines to insure informed consent for sterilizations performed in New York City. Since the NYS Medicaid Program will not pay for services rendered illegally, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City.

Any questions relating to New York City Local Law No. 37 of 1977, should be directed to the following office:

Maternal, Infant & Reproductive Health Program
New York City Department of Health
125 Worth Street
New York, New York 10013
(212) 442-1740

Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are:

- performed solely for the purpose of rendering the client incapable of reproducing;
or,

- if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomies are covered by Medicaid if the client is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

The client or her representative must sign Part I of the ***Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)***.

For hysterectomies, the requirement for the client's signature on Part I of Form DSS-3113 can be waived if:

1. The woman was sterile prior to the hysterectomy;
2. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible.

For Medicaid payment to be made in these two cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency. For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;

3. The woman was not a Medicaid client at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application.

For these cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above in "1" or "2" was met.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the DOH. **Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.**

The NYS Medicaid Program covers abortions which *have been determined to be medically necessary by the attending physician*. Social Services Law 365-a specifies the types of medically necessary care, including medically necessary abortions, which may be provided under the Medicaid Program.

Medically necessary services are those:

"...necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his/her capacity for normal activity or threaten some significant handicap and which are furnished to an eligible person in accordance with this title and the regulations of the Department."

Medicaid also relies on the language from the federal Supreme Court decision *Doe V. Bolton* to further refine the definition for medically necessary abortions.

This decision held that the determination that an abortion is medically necessary "is a professional judgment that may be exercised in the light of all factors - physical, emotional, psychological, familial and the woman's age - relevant to the well-being of the patient. All these factors may relate to health."

The doctor makes the determination of medical necessity and so indicates on the claim form.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to NYC beneficiaries.

Screening Mammography

Screening Mammography is a service covered by the Medicaid Program. The referral needs to be in accordance with medical necessity. This may include establishing baseline data and referring for periodic testing based on age and family history of the patient.

There are general federal requirements to the effect that any physician or other provider of mammography services must be certified under guidelines established in the Mammography Quality Standards Act (MQSA) and implemented by the Food and Drug Administration (FDA) in order to remain lawfully in operation.

These regulations pertain to any person or facility that operates mammography equipment, reads mammograms, or processes mammography images. To become certified, the facility and/or individuals must first be accredited by a federally approved, non-profit organization or state agency. To date, only the American College of Radiology and the State of Iowa have FDA approval to be accrediting bodies.

Facilities with full accreditation from the American College of Radiology, prior to October 1, 1994, will be issued a certificate from the FDA valid for a three-year period.

Facilities that have applied to the American College of Radiology, whose application is still pending final review, will be issued a provisional certificate from the FDA that is valid for six months.

Preferred Physicians and Children Program

The **Preferred Physicians and Children Program** (PPAC) is supervised by the DOH and is an important part of the State's effort to assure children access to quality medical care through the Medicaid Program.

PPAC encourages the participation of qualified practitioners, increases children's access to comprehensive primary care and to other specialist physician services, and promotes the coordination of medical care between the primary care physician or nurse practitioner and other physician specialists.

Nurse Practitioner Eligibility and Practice Requirements

The qualified (**primary care**) nurse practitioner 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 of planning; scheduling of referral appointments with written referral as necessary and with request for follow-up report; and scheduling for necessary ancillary services.

- Agree to 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.

The qualified (**non-primary care**) nurse practitioner 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 consultant 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 an agreement to be subject to cancellation with 30-day notice by either party.

Client Eligibility

PPAC visits/examinations may be claimed for Medicaid clients whose ages range from birth through twenty (20) years.

Covered Services

For the PPAC participating provider the visit/examination is the only service claimed and reimbursed through the PPAC program. Claiming is by PPAC procedure code specific to place of service, such as office.

PPAC visit codes may NOT be used to bill for:

- (a) nurse practitioner services provided in Article 28 clinics and
- (b) contractual nurse practitioner services in emergency rooms.

The PPAC reimbursement system, designed by the DOH, simplifies claiming, and reimburses by weighing a mix of factors, such as patient diagnosis, age and sex; provider location; and the averages of costs for physician care delivery. Fees approximate those of commercial insurers.

Claims for physician services other than the visit/examination will continue to be claimed and reimbursed in accordance with the instructions outlined in this Manual.

Application

Nurse Practitioners may apply to participate in the PPAC program by completion and submittal of the DOH form, "*Application for Enrollment in the PPAC Program*", which constitutes application/agreement to participate in the Medicaid Preferred Physicians and Children Program. These forms must be completed and submitted by nurse practitioners already enrolled in Medicaid as well as by first-time applicants, and by those applying for re-enrollment.

Forms necessary to apply to become a Medicaid and/or PPAC provider may be obtained from the eMedNY website:

<http://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4110-PPAC%20Nurse%20Program%20Packet/4110-PPAC%20Nurse.pdf>

or by calling Computer Sciences Corporation at:

(800) 343-9000 select option 5.

Comprehensive Medicaid Case Management Programs

Comprehensive Medicaid Case Management (CMCM) programs are targeted to specific segments of the Medicaid population who require focused effort to improve access to a wide range of medical, social and other support services for the purpose of improving clients' independent functioning in the community.

While new target groups may be added, the following presents the existing service populations for CMCM:

- Pregnant and parenting teens.

The primary targeted group may consist of any adolescent, male or female, under 21 years of age, who is Medicaid eligible and is a parent residing in the same household with his or her child(ren) or is pregnant. The target group may vary by local social services department (LDSS).

The LDSS determines entry into the program.

- Mentally retarded and developmentally disabled individuals who need comprehensive rather than incidental service and who reside in Family Care Homes, Community Residences, live independently or with family.

The Office of Mental Retardation and Developmental Disabilities Revenue Management Field Offices determine entry into the program.

- Seriously mentally ill individuals who require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community.

A local committee consisting of the County Mental Health Department and other human services providers determines entry into the program.

- Segments of the HIV-positive and at-risk population as follows:
 - women of child bearing age who are HIV-positive,
 - women referred by hospitals participating in the Obstetrical HIV Counseling Testing Care initiative,
 - women who are at high risk of HIV infection,
 - HIV-positive children and adolescents through 20 years of age,
 - HIV-positive clients receiving community based case management in Community Services Programs, Community Based Organizations or other organizations under contract to the AIDS Institute to provide other services, and
 - Family members and co-residents of the targeted clients.

Entry into the program is determined by the case management provider organization.

- Poor women of childbearing age who are pregnant or parenting and infants under one year of age who reside in designated areas of the State where there is high infant mortality. (Sections of New York City and Syracuse.)
- Developmentally delayed infants and toddlers.

The target group consists of infants and toddlers from birth through two years of age who have, or are suspected of having:

- a developmental delay,
- a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as Down's Syndrome or other chromosome abnormalities,
- sensory impairments,
- inborn errors of metabolism, or

- fetal alcohol syndrome.

These children and their families require ongoing and comprehensive rather than incidental case management (service coordination).

Entry into this program is determined by the designated municipal early intervention agency in accordance with the regulations of the DOH.

LDSS' are informed by means of **Local Commissioners Memoranda** of the names and contact numbers for all CMCM providers serving clients within their district.

Note: Not all districts have all of the above programs.

Drug Utilization Review Programs

Drug Utilization Review (DUR) programs are intended to assure that prescriptions for outpatient drugs are appropriate, medically necessary and not likely to result in adverse medical consequences. DUR programs help to ensure that the patient receives the proper medicine at the right time in the correct dose and dosage form.

The benefits of DUR programs are:

- reduced Medicaid costs,
- reduced hospital admissions,
- improved health for Medicaid clients, and
- increased coordination of health care services.

The Federal legislation requiring states to implement DUR programs also requires states to establish DUR Boards whose function is to play a major role in each State's DUR program. The DOH established a DUR Board comprised of five physicians, five pharmacists and two persons with expertise in drug utilization review and one designee of the Commissioner of Health. The Board is administered and maintained by the DOH.

The two components of NYS' DUR Program are Retrospective DUR (RetroDUR) and Prospective DUR (ProDUR). While the two programs work cooperatively, each seeks to achieve better patient care through different mechanisms.

RetroDUR

The RetroDUR program is designed to educate physicians by targeting prescribing patterns, which need to be improved. Under RetroDUR, a review is performed

subsequent to the dispensing of the medication, while ProDUR requires a review to be done prior to dispensing the prescription.

The primary goal of RetroDUR is to educate physicians through alert letters, which are sent to practitioners detailing potential drug therapy problems due to:

- therapeutic duplication,
- drug-disease contraindications,
- drug-drug interactions,
- incorrect drug dosage or duration of drug treatment,
- drug allergy interactions and
- clinical abuse/misuse.

It is expected that physicians who receive alert letters identifying a potential problem relating to prescription drugs will take the appropriate corrective action to resolve the problem.

ProDUR

The mandated Prospective Drug Utilization Review Program (ProDUR) through the Medicaid Eligibility Verification System (MEVS), is a point-of-sale system which allows pharmacists to perform on-line, real-time eligibility verifications, electronic claims capture (ECC) and offers protection to Medicaid clients in the form of point-of-sale prevention against drug-induced illnesses.

The ProDUR/ECC system maintains an on-line record of every Medicaid client's drug history for at least a 90-day period. The pharmacist enters information regarding each prescription and that information is automatically compared against previously dispensed drugs, checking for any duplicate prescriptions, drug-to-drug contraindications, over and under dosage and drug-to-disease alerts, among other checks.

In the event that this verification process detects a potential problem, the pharmacist will receive an online warning or rejection message. The pharmacist can then take the appropriate action; for example, contacting the prescribing physician to discuss the matter. The outcome might be not dispensing the drug, reducing the dosage, or changing to a different medication.

Section III - Basis of Payment for Services Provided

Payment for services provided by nurse practitioners will be in accordance with fees established by the DOH and approved by the Division of the Budget.

Payment for services provided by a nurse practitioner who is paid a salary/compensated by a medical facility reimbursed under the Medicaid Program for its services on a rate basis will be made on a fee for service basis only if the cost of the nurse practitioner's services is not included in the facility's rate.

Payment to a nurse practitioner is based upon provision of a personal and identifiable service to the client. This would include such actions as:

- Reviewing the client's history and physical examination results and personally examining the client;
- Confirming or revising diagnoses;
- Determining and carrying out the course of treatment to be followed;
- Assuring that any medical supervision needed by the patient is furnished;
- Conducting review of the patient's progress;
- Identifying in the patient's medical records the nature of the personal and identifiable service that is provided.

The services of nurse practitioners are reimbursable directly to the enrolled nurse practitioner or to the employing physician's group or multi-service group which employs him/her.

All nurse practitioners must be enrolled in the Medicaid Program in order to bill Medicaid on a fee-for-service basis regardless of whether payment is made to them or to their employer.

Nurse Practitioners who are enrolled in the PPAC Program or the MOMS Program will be paid in accordance with the enhanced fees for those programs.

Reimbursement will not be made for appointments for medical care which are not kept, or for services rendered to a client over the telephone.

The completion of medical forms may be necessary in certain situations but such completion does not justify a separate bill to Medicaid.

The cost of the *NYS Triplicate Prescription Form* is covered in the evaluation and management fee; additional billing to the client for a covered cost is an unacceptable practice.

Nurse practitioners who are enrolled in the Medicaid Program may not refuse to provide services to a Medicaid client because of third-party liability for payment for the service, nor may they bill a patient with Medicare coverage for Medicare coinsurance or deductible amounts. It is also contrary to State laws for a non-physician entrepreneur to employ nurse practitioners for the provision of health care services.

Furnishing or ordering medical care, services or supplies that are substantially in excess of the client medical needs may result in recoupment of the cost of those services, drugs or supplies from the ordering nurse practitioner.

Payment cannot be made for medical care if the original claim is received more than two years after the original date of service. The only acceptable exceptions to this policy are:

- 1) litigation involving the Department concerning the claim; and
- 2) delay in Medicaid client eligibility determination including fair hearing.

Nurse practitioners resubmitting claims after two years from the date of service should be maintaining documentation showing that the original submittal was within two years and that the submittal was either within 90 days or showing circumstances justifying waiver of the 90-day submission.

When you encounter a situation where you historically have not received an insurance payment either directly or through the cooperation of a Medicaid client or a legally responsible relative, you can receive that payment by following these steps:

- Contact the Third Party Resources worker in the local department of social services, which is fiscally responsible for the Medicaid patient;
- Advise the Third Party worker that you would like to be paid directly by the insurance carrier for your claims because the legally responsible relative or MA client has been uncooperative in the past in paying you the insurance payment that they received for your service. You will need to identify the MA client who is being treated in order for the local social services district to assist you.

The Third Party worker will complete and furnish you with two forms, **An Authorization to Act as Agent** and **Subrogation Notice to Insurance Carrier**.

In addition to assuring receipt of payment for your services, your cooperation in billing the insurance company could provide you with a higher reimbursement rate than the Medicaid rate for the same service.

Payment for Immunization

Children under nineteen (19) years of age with Medicaid coverage are among children for whom the Federal government now supplies certain routine childhood vaccines at no cost to providers who are registered with the Vaccines for Children (VFC) Program.

The vaccines available without charge are distributed in New York through the New York VFC Program, administered by the DOH. For Medicaid eligibles under nineteen (19) years of age, Medicaid will not reimburse providers for the cost of vaccine available through VFC without charge.

Medicaid enrolled physicians, nurse practitioners and referred ambulatory providers must be registered with the VFC program in order to receive reimbursement for administering VFC-provided vaccine to Medicaid eligibles under nineteen (19) years of age. The current Medicaid administration fee for VFC-provided vaccine is \$17.85 per immunization, i.e. per vaccine code. The appropriate Evaluation and Management Service may also be billed.

To obtain more information and/or registration material, call:

**800-KID-SHOTS
(800-543-7468).**

When claiming for immunization procedures for Medicaid eligibles under nineteen (19) years of age, charge the administration fee of \$17.85 per immunization. When claiming for these procedures for Medicaid eligibles ages nineteen (19) or over, enter the cost to you of the vaccine used for the patient plus \$2.00 which covers the administration fee.

You will be paid, for persons ages nineteen (19) or over, the \$2.00 administration fee plus the lower of your cost or the monthly fee on file in eMedNY for the date the immunization was administered.

The appropriate Evaluation and Management Service may also be billed.

Utilization Threshold

Under the Utilization Threshold Program, it is necessary for providers to obtain an authorization from MEVS to render services for physician, clinic, laboratory, pharmacy, and dental clinic care. This authorization to render services will be given unless a client has reached his/her utilization threshold limits.

At this point, it is necessary for an ordering provider to submit a special "Threshold Override Application" form in order to obtain additional services. In certain special circumstances, such as emergencies, providers do not have to receive authorization from MEVS. Arrangements have also been made to permit a provider to request a service authorization on a retroactive basis.

In requesting a retroactive service authorization you risk your request being denied if the client has reached his/her limit in the interim. After you receive an authorization your claim may be submitted to our Fiscal Agent for processing. The regulation requiring claims to be submitted within 90 days of the date of service still applies.

- Laboratories and pharmacies may not submit a request for an increase in laboratory or pharmacy services. Such requests are to be submitted by the ordering provider.

Laboratories that need to determine whether tests are needed on an emergency or urgent basis shall consult with the ordering provider, unless the order form indicates that an urgent or emergency situation exists.

- Those limited laboratory services, which can be rendered by a physician or podiatrist in private practice to his/her own patients do not count toward the laboratory utilization threshold.
- Utilization Thresholds will not apply to services otherwise subject to thresholds when provided as follows:
 - ▶ "Managed care services" furnished by or through a managed care program, such as a health maintenance organization, preferred provider plan, physician case management program or other managed medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program;
 - ▶ Services otherwise subject to prior approval or prior authorization;
 - ▶ Reproductive health and family planning services, including: diagnosis, treatment, drugs, supplies and related counseling furnished or prescribed by or under the supervision of a physician for the purposes of contraception, sterilization or the promotion of fertility. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease and pregnancy and pelvic abnormalities;
 - ▶ Child/Teen Health Program services;
 - ▶ Methadone maintenance treatment services;
 - ▶ Services provided by private practitioners on a fee-for-service basis to inpatients in general hospitals and residential health care facilities;
 - ▶ Hemodialysis services;
 - ▶ School health project services;

- ▶ Obstetrical services provided by a physician, hospital outpatient department, or free-standing diagnostic and treatment center; and
- ▶ Primary care services provided by a pediatrician or pediatric clinic.

Section IV- Unacceptable Practices

All services ordered for Medicaid clients must be medically necessary and related to the specific complaints and symptoms of the patient. The State may take administrative action against ordering providers who cause unnecessary utilization of services by inappropriate ordering. Further, the State may seek restitution for monetary damage to the Program resulting from inappropriate and/or excessive ordering of services.

For the definition and general discussion of unacceptable practices, see [Information For All Providers, General Policy](#).

The following discussion and examples of unacceptable practices are specific to the relationship between an ordering practitioner and a service provider.

Examples of Unacceptable Practices

Undocumented Necessity

When an ordering provider fails to document properly the specific need for ordered items or supplies in a patient's medical record, or, when a practitioner furnishes or orders medical care, services or supplies substantially in excess of a client's medical needs, the State may require repayment from the person furnishing the excessive services from the person under whose supervision they were furnished or from the person ordering the excessive service.

Bribes and Kickbacks

Social Services Regulations 515.2(b) (5) (found at <http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm>) describes several inappropriate ways of giving discounts or reduced prices. For example, the State will investigate a situation where a laboratory is renting space from a physician's group for operation of a collecting station or for any other purpose.

Rental may be for no more than fair market value of the rental space and the rental amount may not be affected by testing ordering volume or value. Investigation for possible criminal offenses, however, may result from these relationships pursuant to 42 USC 1320a-7b.

Similarly, activities which are prohibited include the placement of phlebotomists in a health purveyor's office, the provision of secretarial and clerical personnel to ordering providers or the acceptance of such personnel, the provision of supplies and equipment such as fax machines, personal computers, medical waste disposal services, etc.

False Claims, False Statements and Conspiracy

All of the following are examples of conduct which constitutes fraud and abuse:

- Submitting, or causing to be submitted, a claim to the Program for unfurnished medical care, services or supplies.
- Submitting, or causing to be submitted, a claim to the Program for unnecessary medical care, services or supplies.
- Making, or causing to be made, any false statement or misrepresentation of material facts in submitting a claim to the Program.
- Making any agreement to defraud the Program by obtaining or aiding anyone to obtain payment of any false claim to the Program.

Section V - Ordering Services and Supplies

The purpose of ordered services is to make available to the private practitioner those services needed to complement the provision of ambulatory care in his/her office.

This is not meant to replace those services which are expected to be provided by the private practitioner nor is it meant to be used in those instances when it would be appropriate to:

- admit a patient to a hospital,
- refer a patient to a specialist for treatment, including surgery, or
- refer a patient to a specialized clinic for treatment.

Services must be provided in accordance with the ordering practitioner's treatment plan.

Services must be ordered, in writing, by a licensed physician or other person, so authorized by law.

In emergencies only, the request of the ordering practitioner may be verbal; however, **the verbal request must be followed by a written order.**

The written order must include, but is not limited to, the following elements of information:

Client Information

- Name
- Medicaid I.D. Number
- Year of Birth
- Sex

Ordering Provider Information

- *Provider I.D. Number
(if not Medicaid-enrolled use
license number)
- Name
- Address
- Telephone Number
- Services Requested
- Date of Request
- Ordering Provider's Original
Signature

Client Information

When applicable:

- Diagnosis
- Medicare H.I.C. Number or
Other Insurance Information
- Indication if Service Related to:
Accident
Crime
Family Planning
Physically Handicapped
Children's Program
Abortion or Sterilization
- Prior Approval Number

When registered physician assistants order services, the order must contain the supervising physician's NY Medicaid Provider identification number (or license number if not enrolled in the NY Medicaid Program).

Ordered Ambulatory Services

A hospital or diagnostic and treatment center may perform an ordered ambulatory service only when the treatment, test or procedure has been ordered in writing and is the result of a referral made by a:

- licensed physician,
- nurse practitioner,
- dentist,
- podiatrist,
- registered physician's assistant, or
- midwife.

The order must be signed and dated by the ordering provider.

In emergencies only, the request of the ordering practitioner may be verbal; however, a written order must later be obtained by the hospital or diagnostic and treatment center.

In all cases, the written order must be received by the facility within a period of two working days from the time of the verbal request.

Ordered ambulatory services include:

- Laboratory services, including pathology;
- Diagnostic radiology services, including CT scans;
- Diagnostic nuclear medicine scanning procedures;
- Medicine services, including specific diagnostic and therapeutic procedures such as electrocardiograms, electroencephalograms, and pulmonary function testing;
- Diagnostic ultrasound services, including ultrasonic scanning and measurement procedures such as echoencephalography, echocardiography and peripheral vascular system studies;
- Psychological evaluation services, performed by a clinical psychologist, including testing; and

- Therapeutic services, including radiotherapy, chemotherapy and rehabilitation therapy services.

At the time ordered ambulatory services are prescribed, the following conditions may not exist:

- The client may not be under the primary care/responsibility of the Article 28 facility where the service is to be performed; and/or
- The ordering practitioner may not be an employee of the Article 28 facility where the service is to be performed.

In accordance with the aforementioned policy, the attending/ordering practitioner will be reimbursed on a fee-for-service basis for those professional services rendered in the provider's office, as referenced within the appropriate Provider Manual/Fee Schedule (e.g., Physician, Dental etc.). The facility will be reimbursed on a fee-for-service basis for those services rendered within the facility, in conjunction with the guidelines set forth within the **Ordered Ambulatory Manual**.

Physical therapy, occupational therapy and speech-language pathology services may only be ordered by physicians, nurse practitioners, or physician's assistants.

Reports of Services

Payment will be made for an ordered service only if the report of that test, procedure or treatment has been furnished directly to the ordering practitioner.

Payment for Services

The ordering practitioner will not be reimbursed for services that have been furnished by the service provider. Payment of any item of medical care is made only to the provider actually furnishing such care.

Drugs

Drugs must be ordered in a quantity consistent with the health needs of the patient and sound medical practice. The maximum amount, which is allowed to be dispensed under the Medicaid program, is based on whether or not a prescription is considered long-term maintenance.

Long-term maintenance drugs are:

- *drugs ordered or prescribed with one or more refills in quantities of a 30 day supply or greater,*

- *drugs ordered or prescribed without refills in quantities of a 60 day supply or greater,*
- *drugs ordered or prescribed for family planning purposes or,*
- *prescriptions written and dispensed on the official New York State triplicate prescription form for up to a three month supply when written in conformity with the Controlled Substance Act (title IV or article 33 of the Public Health Law).*

Drugs, which do not meet the long-term maintenance definition, are to be dispensed in quantities of up to a 30-day supply or 100 doses, whichever is greater. One hundred doses are 100 units of a solid formulation. *The quantity ordered or prescribed must be based on generally accepted medical practice.*

A fiscal order or prescription for drugs and supplies may not be refilled unless the prescriber has indicated on the prescription/order form the number of refills.

Unless a lesser quantity of refills is otherwise indicated, a **maximum of 5 refills** is permitted by Medicaid for supplies, prescription and non-prescription drugs.

The pharmacist shall dispense a generic drug, whenever available, if an FDA approved therapeutically and pharmaceutically equivalent product is listed in the publication "Approved Drug Products with Therapeutic Equivalence Evaluations" (The Orange Book), unless the prescriber writes "daw" (dispense as written) on the prescription form. However, for certain brand name products to be eligible for Medicaid reimbursement at the brand name (EAC) price, prescribers must also certify that they require the brand name drug by writing directly on the face of the prescription "brand necessary" or "brand medically necessary" in their own handwriting. A rubber stamp or other mechanical signature device may not be used.

Nurse practitioners may receive complaints from pharmacies, which are denied for drugs ordered by nurse practitioners. It may be helpful to remind the pharmacy that the claim for Medicaid payment must show the license number of the nurse practitioner preceded by a zero. e.g., license number F340123 must be entered as 0F340123.

Hospital-Based Ambulatory Surgery Program

Regulations define a hospital-based ambulatory surgery service as a "...hospital-based service involving surgery on patients under anesthesia in an operating room and necessitating a hospital stay of less than 24 hours in duration. Hospital-based ambulatory surgery patients will typically utilize the operating room, recovery room, anesthesia services and other related ancillary services in the course of their treatment, and will come to or be brought to the hospital for purposes of a surgical procedure. Outpatient surgical procedures typically performed in a doctor's office or ambulatory

treatment room setting shall not be considered hospital-based ambulatory surgery services."

When an ambulatory patient requires surgery in a hospital or diagnostic and treatment center operating room, payment may be made to the facility at the appropriate ordered ambulatory operating room fee. The operating physician may not bill Medicaid directly for these services if he/she is employed by the hospital or diagnostic and treatment center and if any part of his/her salary is for direct patient care. In such cases, payment to the facility for use of the operating room covers the physician's services. If the physician is not employed by the hospital, he/she may bill independently using the fee schedule in this Manual.

Laboratory Tests

In addition to those elements of information listed, orders for laboratory tests must contain the following:

- Date of Specimen Collection
- Time of Specimen Collection, if appropriate
- Patient Status Information (e.g. date of LMP) if appropriate
- Other Information Required by Regulation

A clinical laboratory may examine a specimen only when the test has been ordered in writing by a licensed physician or a qualified practitioner. Laboratory test orders must be written:

- (1) on a physician's or a qualified practitioner's prescription form or imprinted stationery, with all tests to be performed individually listed and written by a practitioner, or
- (2) on a pre-printed order form issued by a hospital or other Article 28 facility for laboratory services to be provided by the facility's laboratory, or
- (3) on a preprinted order form issued by a free-standing independent clinical laboratory on which all tests are individually ordered.

Orders for laboratory tests must indicate the diagnosis, symptomatology, suspected condition or reason for the encounter, either by use of the appropriate ICD-9-CM code or a narrative description. Use of the ICD-9-CM code V72.6 does not satisfy this requirement.

It is the responsibility of the ordering practitioner to ascertain that the laboratory to which he/she is referring specimens or patients has not been excluded from participation in

the Program and holds appropriate New York State and/or New York City Laboratory permits.

Medicaid reimburses laboratories for most services in a manner that precludes the cost savings often realized by other payors for tests bundled into laboratory specific panels or profiles. Ordering practitioners should be selective in their determination of which tests are appropriate given the patient's circumstances (e.g. medical history). For example, the repeat ordering of a twelve-test chemistry profile in a follow-up to a single abnormal result is inappropriate if a repeat of the single test is sufficient to address the clinical question.

Medically necessary laboratory tests are reimbursable by Medicaid. However, certain specific requirements apply to the ordering of all laboratory tests.

Ordering Laboratory Tests from an Independent Clinical Laboratory

Laboratory tests ordered from an independent laboratory must be individually ordered by the practitioner. No payment will be made to independent clinical laboratories for laboratory tests ordered in a panel/profile format or for tests ordered in any other type of grouping or combination of tests. Medicaid payment to the independent clinical laboratory will be disallowed for individually ordered tests which are ordered on a form which also contains an order for a grouping or combination of tests.

Certain specific tests may continue to be ordered in a test grouping or panel format. The following tests may be ordered as a single test on the order form:

- CBC
- Urinalysis

In addition, the following automated chemistry tests may be ordered from an independent clinical laboratory as a panel test, if they include the specific components listed below:

- SMA-6
 - ▶ Glucose
 - ▶ BUN (Urea Nitrogen)
 - ▶ Sodium
 - ▶ Potassium
 - ▶ Chloride
 - ▶ Carbon Dioxide (CO₂)
- SMA-12
 - ▶ Glucose
 - ▶ BUN

- ▶ Calcium
- ▶ Phosphorus
- ▶ Protein
- ▶ Albumin
- ▶ Uric Acid
- ▶ Cholesterol
- ▶ SGOT
- ▶ Alkaline Phosphates
- ▶ Bilirubin
- ▶ Creatinine

With respect to the automated chemistry tests (SMA) noted above, these tests grouping should not be ordered for every patient routinely. The SMA-6 and SMA-12 test panels are not recognized by the Department as general screening tests for use on all patients without clinical justification. The need for the SMA test (as a whole) must be justified in the patient's medical record. The nurse practitioner should still order individual chemistry components when he or she feels that the individual components will meet diagnostic needs.

A nurse practitioner who feels it is necessary to order both an SMA-6 and an SMA-12, for the same patient on the same date of service would be expected to justify the medical necessity for each of the individual components of both the SMA-6 and the SMA-12 in the patient's medical record.

The above test ordering requirements apply only to laboratory tests ordered from an independent clinical laboratory. Laboratory tests ordered from a clinic or hospital-based laboratory may continue to be ordered in a panel/profile configuration as designated on the laboratory test requisition form.

Medicaid Transportation

Transportation services provided within the Medicaid Program are intended to assure that clients are able to access necessary medical care and services covered under Medicaid.

Clients who can get to medical care on their own should not have transportation services ordered for them.

The transportation provided should be the least intensive mode required based on the client's current medical condition. You should be aware that, according to Department regulation 504.8(a):

“Providers shall be subject to audit by the Department and with respect to such audits will be required... (2) to pay restitution for any direct or indirect monetary damage to the program resulting from their improperly or inappropriately

furnishing services or arranging for ordering, or prescribing care, services or supplies...”

Only specific medical practitioners, including nurse practitioners, may order non-emergency ambulance, ambulette and livery transportation.

Clinics, hospitals, and other medical facilities are allowed to order transportation on behalf of a nurse practitioner; however, evidence of the need for such transportation should be documented by one of the ordering nurse practitioner.

In New York City, all ordering practitioner(s) must complete the MAP 2015 form. To obtain the form, call:

(212) 630-1513.

The Medicaid Program may pay the costs incurred by Medicaid clients only when traveling to and from medical care and services covered under the Medicaid Program and only when the client has no other way to get to the medical care.

The medical practitioner requesting livery or taxi, ambulette or ambulance, is responsible for ordering the appropriate modes of transportation for the Medicaid client.

A provider should not order these services, if the client can get to medical care on his/her own.

When a client has reasonable access to the mode of transportation used for normal activities of daily living, such as shopping and recreational events, this mode should also be used to travel to and from medical appointments.

A client is not entitled to Medicaid transportation for occasional travel to medical appointments, unless the lack of reimbursement would cause undue financial hardship. For example, a client who goes to the doctor once a month can typically be expected to pay his/her own bus or subway fare.

When ordering the appropriate mode of transportation a client should utilize in accessing medical care and services, a basic consideration should be the Medicaid client's current level of mobility and functional independence.

It is generally expected that, due to the extensive network of mass transportation in New York City, New York City Medicaid clients should use mass transportation to travel to and from medical appointments unless a specific condition contraindicates such use.

Statewide Guidelines for Ordering Livery or Taxi Transportation

- The client does not live within walking distance of the place of service, and does not have access to a personal vehicle or mass transit.

- The client is able to travel independently, but due to a debilitating physical or mental condition, cannot use a personal vehicle or the mass transit system.

A client's preference is not a legitimate reason to order livery or taxi transportation if a client can access a personal vehicle or mass transit.

- The client is traveling to and from a location, which is inaccessible by mass transit, and does not have access to a personal vehicle.
- The client cannot access the mass transit system or a personal vehicle due to temporary, severe weather, which precludes use of the normal mode of transportation.

While the above conditions may demonstrate the possible need for livery or taxi service, the functional ability and independence of the Medicaid client should also be considered in determining the mode of transportation required.

Statewide Guidelines for Ordering Ambulette Transportation

- The client **requires** the personal assistance of the driver in entering and exiting the client's residence, the ambulette, and the medical facility.
- The client is wheelchair-bound (non-collapsible or one which requires a specially configured vehicle).
- The client has a mental impairment and requires the personal assistance of the ambulette driver.
- The client has a severe, debilitating weakness or is mentally disoriented as a result of medical treatment and requires the personal assistance of the ambulette driver.
- The client has a disabling physical condition, which requires the use of a walker, crutch, or brace and is unable to use a livery service or bus.

Note: If the client brings an escort on the trip, and the presence of the escort obviates the need for the personal assistance of the ambulette employee, it is not appropriate to order ambulette services.

While the above conditions may demonstrate the possible need for ambulette service, the functional ability and independence of the Medicaid client should also be considered in determining the mode of transportation required. Other conditions not listed may require the use of an ambulette service.

The key to the use of an ambulette service is that the assistance of the driver or the need for a specially configured vehicle is required. Implicit in the use of an

ambulette is the need for door-to-door service. Ambulette may not be ordered based on client preference.

Some ambulette services provide stretcher service when the person transported must be transported in a recumbent position and is not in need of basic life support care. Persons requiring stretcher transport without the need of life support services can use these specialized ambulette vehicles.

Statewide Guidelines for Ordering Non-emergency Ambulance Transportation

- The client must be transported on a stretcher and/or requires the administration of life support equipment by trained medical personnel.

The use of a non-emergency ambulance is indicated when the client's condition would contraindicate any other form of transport.

Section VI - Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Ordered Ambulatory Service

An ordered ambulatory service is a specific service performed by a hospital or diagnostic and treatment center possessing an operating certificate issued by the NYSDOH.

Such service is provided on an ambulatory basis, upon the written order of a qualified physician, nurse practitioner, registered physician's assistant, dentist or podiatrist to test, diagnose or treat a client or a specimen taken from a client.

Such services may include a singular occasion of service or a series of tests or treatments provided by or under the direction of a physician. "Ordered Ambulatory Services" were previously known as "Referred Ambulatory Services."

Ordered Ambulatory Patient

An ordered ambulatory patient is one who is tested, diagnosed or treated on an ambulatory basis in a hospital or diagnostic and treatment center upon the referral and written recommendation of a physician or recognized practitioner who did not make that referral and recommendation from clinical outpatient, emergency outpatient, or inpatient area of that hospital or another Article 28 facility certified to provide the same service.

Ordered Service

An ordered service is a specific, medically necessary service or item performed by or provided by a qualified provider upon the written order of a qualified practitioner.

Examples of ordered services include:

- laboratory services,
- pharmacy services,
- durable medical equipment,
- private duty nursing,
- medical services,
- radiology services,
- cardiac fluoroscopy,
- echocardiography, and
- non-invasive vascular diagnostic studies.

Services of podiatrists in private practice are available only for persons under age 21 with a written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

The purpose of ordered services is to make available to the private practitioner those services needed to complement the provision of ambulatory care in his/her office.

It is not meant to replace those services which are expected to be provided by the private practitioner nor is it meant to be used in those instances when it would be appropriate to admit a patient to a hospital, to refer a patient to a specialist for treatment, including surgery or to refer a patient to a specialized clinic for treatment.

Services must be provided in accordance with the ordering practitioner's treatment plan.