# NEW YORK STATE
# MEDICAID PROGRAM

# INFORMATION FOR ALL PROVIDERS

# INTRODUCTION

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# Preface

The purpose of this Manual is the provision of information and guidance to those providers who participate in the New York State Medicaid Program. It is designed to provide instructions for the understanding and completion of forms and documents relating to billing procedures and to serve as a reference for additional information that may be required.

Pertinent policy statements and requirements governing the Medicaid Program have been included. The Manual has been designed to easily incorporate changes since additions and periodic clarifications will be necessary. It should serve as a central reference for updated information.

Providers are responsible for familiarizing themselves with all Medicaid procedures and regulations currently in effect and as they are issued.

The Department of Health publishes a monthly newsletter, the *Medicaid Update*, which contains information regarding Medicaid programs, policy and billing. The *Update* is sent to all active enrolled providers.

New providers need to be familiar with the past issues of *Medicaid Update* to have current policy and procedures.

Past issues of *Medicaid Update* are available at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

# Foreword

The New York State Department of Health (DOH) is the single State agency responsible for the administration of the New York Medicaid Program under Title XIX of the Social Security Act.

The primary purpose of the Medicaid Program is to make covered health and medical services available to eligible individuals. As the single State agency, DOH promulgates all necessary regulations and guidelines for Program administration, as well as develops professional standards for the Program, develops rates and fees for medical services, hospital utilization review and professional consultation to local department of social service officials for determining adequacy of medical services submitted for Medicaid reimbursement.

The Department is required to maintain a Medicaid State Plan that is consistent with provisions of Federal law and regulations. Administrative functions include development of Program policy, determination of recipient eligibility, ambulatory care utilization review, detection of possible fraud and abuse, and supervision of the Fiscal Agent and all its functions.

In order to carry out aspects of the professional administration of the Program, the DOH's Office of Medicaid Management (OMM) works in conjunction with other state agencies such as the Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcohol and Substance Abuse Services (OASAS) and the State Education Department (SED) to ensure that the needs of the special populations that these agencies serve are addressed within the parameters of the Medicaid Program.

> Additionally, the DOH works with New York's local departments of social services to administer and fund the Medicaid Program.

The Director of the New York State Division of the Budget promulgates all fees and rates for the Medicaid Program (with the exception of those which by statute are set by OMH, OMRDD and OASAS).

# Medicaid Management Information System

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed and implemented.

New York State's MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The New York State eMedNY design is based on the recognition that Medicaid processing can be highly automated and that provider relations and claims resolution require an interface with experienced program knowledgeable people.

> This approach results in great economies through automation, yet eliminates the frustration which providers frequently encounter in dealing with computerized systems.

DOH has contracted with Computer Sciences Corporation (CSC) to be the Medicaid fiscal agent.

CSC, in its role as Fiscal Agent, maintains a Medicaid claims processing system to meet New York State and Federal Medicaid requirements, and performs the following functions:

- Receives, reviews and pays claims submitted by the providers of health care for services rendered to eligible patients (recipients).

- Interacts with the providers through its Provider Services personnel in order to train providers in what the Medicaid requirements are and how to submit claims; responds to provider mail and telephone inquiries; maintains and issues forms, and notices, to providers.

- Maintains the Medicaid Eligibility Verification System (MEVS).

## Key Features

eMedNY has several key features that enable the system to achieve its objectives.

- **Claims Payment**
  This aspect of eMedNY generates prompt payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied and pended claims.

- **Flexibility**
  For rate-based providers, the system has the flexibility to process individual claim lines submitted on a single claim separately. It will not deny payment of the entire

invoice if one line is pended or requires manual pricing.
For fee-for-service providers who utilize ePACES the system can process claims (with up to 4 claim lines) in "real-time". Real time means that the claims process through adjudication within seconds.

- **Manual Review**
  All paper claims are manually screened on the day of receipt prior to computer processing. Any omissions or obvious errors will result in the return of the claim form to the provider.

- **Inquiry Procedures**
  The Fiscal Agent handles written and telephone requests for information. Detailed procedures can be found in Information for All Providers, Inquiry.

- **Service Bureaus**
  The Fiscal Agent will cooperate with the provider's computer service bureau to ensure that the automated claim input meets eMedNY requirements.

- **Provider and Recipient Eligibility**
  The DOH is responsible for the determination of eligibility of providers in the New York Medicaid Program. Local departments of social services retain the responsibility for determining recipient eligibility.

- **Service Limitations and Exclusions**
  The DOH maintains the responsibility for determining covered services and exclusions in the Medicaid Program.

- **Continuing Communications**
  To ensure a flow of information from the State and Fiscal Agent to the providers, community bulletins, newsletters and updates are mailed periodically. Additionally, most information can be found online at:

  http://www.emedny.org/.

# NEW YORK STATE
# MEDICAID PROGRAM

## INFORMATION FOR ALL PROVIDERS

## GENERAL POLICY

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# Section I – Enrollee Information

The New York State Department of Health (Department, DOH) exercises overall supervision of the Medicaid Program. Enrollee eligibility, however, is handled by the fifty-eight local departments of social services (LDSS) and the New York City Human Resources Administration (HRA).

Generally, the following groups are eligible for Medicaid in New York State:

- Citizens and certain qualified persons who are:

  - eligible for Low Income Families (families with children under age 21; persons under age 21 living alone; and pregnant women); or

  - in receipt of or eligible for Supplemental Security Income (individuals who are aged, certified blind or disabled); or

  - children on whose behalf foster care maintenance payments are being made or for whom an adoption assistance agreement is in effect under Title IV-E of the Social Security Act; or

  - individuals between the ages of 21 and 65 not living with a child under the age of 21, not certified blind or disabled, and not pregnant, whose income and resources are below the Public Assistance Standard of Need.

- Citizens and certain qualified persons who meet the financial and other eligibility requirements for the State's Medically Needy Program.

  These persons have income and resources above the cash assistance levels, but their income and resources are insufficient to meet medical needs.

  These groups generally include:

  - infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level;

  - children age one through five whose family income is at or below 133% of the federal poverty level;

  - other children with family income at or below 100% of the federal poverty level, including all children under age 19;

  - families with children under age 21 who do not have two parents in the household capable of working and providing support;

- persons related to the Supplemental Security Program (i.e., aged, certified blind or disabled);

- adults in two-parent households who are capable of working and providing support to their children under age 21;

- a special limited category of Medicaid eligibility is available for individuals who are entitled to the payment of Medicare deductibles and coinsurance, as appropriate, for Medicare-approved services. An individual eligible for this coverage is called a Qualified Medicare Enrollee (QMB).

  Any individual who is fully Medicaid-eligible and has Medicare coverage, even if not a QMB, is also entitled to have Medicare coinsurance and deductibles paid for by Medicaid. An individual may also have these benefits as a supplement to other Medicaid eligibility. QMB status is identified through the Medicaid Eligibility Verification System (MEVS).

## Identification of Medicaid Eligibility

It is important to determine Medicaid eligibility for each medical visit since Medicaid eligibility is date specific. Each enrollee should have only one Common Benefit Identification Card (CBIC) or Temporary Medicaid Authorization paper document. If the enrollee presents a Temporary Medicaid Authorization paper document, there should be no obstacle to payment of the claim because of the enrollee's ineligibility for Medicaid, for medical services provided within the dates of coverage listed on the form.

The Temporary Medicaid Authorization is completed by the LDSS worker and includes the enrollee's:

- Name;
- Date of Birth;
- Social Security Number;
- Case Number;
- Caseworker's name and telephone number;
- Issuing County; and
- Type of Medicaid coverage authorized;
- Any restrictions that exist;
- Authorized dates of coverage.

*It is recommended that the provider make a copy of the Temporary Medicaid Authorization and return the original to the enrollee, as he or she may have further medical needs during the authorization period.*

The CBIC has the capability of being activated and authorized for several assistance programs at the same time. It is important for the provider to check the actual card through the MEVS system to assure there is current, active Medicaid coverage. This card may or may not have a photograph on it, as this is not a requirement for some enrollees because of their category or circumstances.

Sometimes, an enrollee may present the provider with more than one card for the same individual. This may occur when the enrollee has reported to the district that their card is lost and is then found after the LDSS issues a replacement card. In these cases, check each card for the sequence number, which is found to the right of the access number on the bottom of the front of the card. The highest sequence number is the most recently issued card, and is usually the one that is authorized with current benefits.

The permanent, plastic CBIC does not contain eligibility dates or other eligibility information. **Therefore, presentation of a CBIC alone is not sufficient proof that an enrollee is eligible for services. Each of the Benefit Cards must be used in conjunction with the MEVS process.** Through this process, the provider must be sure to verify if the enrollee has any special limitations or restrictions.

If the provider does not verify the eligibility and extent of coverage of each enrollee each time services are requested, then the provider will risk the possibility of non-reimbursement for services provided as **the State cannot compensate a provider for a service rendered to an ineligible person.** Eligibility information for the enrollee must be determined via the MEVS.

Eligible enrollees in voluntary child care agencies and residential health care facilities are issued Medicaid ID numbers which are maintained on a roster. A CBIC is usually not issued for these enrollees. If a card is required, a non-photo CBIC will be issued by the LDSS. It is the responsibility of the voluntary child care agency or the residential health care facility to give the enrollee's Medicaid ID number to other service providers; those providers must complete the verification process via MEVS to determine the enrollee's eligibility for Medicaid services and supplies.

The MEVS Provider Manual is available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

## Eligible Enrollees

Swiping the Medicaid card and/or reviewing the paper authorization and making no further comment to the Medicaid enrollee concerning payment for services, leads the enrollee to assume that you, as the provider, will accept Medicaid payment for the service about to be provided.

The Department supports this assumption and expects the provider to bill Medicaid, not the enrollee, for that service.

## Ineligible Patients

If you swipe the plastic card and find that the individual is not eligible, then you must inform the patient.

A provider may charge a Medicaid enrollee for services only when both parties have agreed prior to the rendering of the service that the enrollee is being seen as a private pay patient; this must be a mutual and voluntary decision. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient's medical record.

## Emergency Situations

In emergency situations where questions regarding health insurance are not normally asked, the Department expects you to accept the patient as a Medicaid enrollee; however, the enrollee is responsible for providing both the ambulance company and the hospital emergency room billing staff with a Medicaid number when it is requested at a later time.

If the enrollee is not cooperative in providing his or her Medicaid information after the transport or emergency room visit has occurred, then the patient may be billed as private pay. The Department does, however, expect that diligent efforts will be made to obtain the Medicaid information from the patient.

## Services Available Under the Medicaid Program

Under the Medicaid Program, eligible individuals can obtain a wide variety of medical care and services. To acquaint providers with the scope of services available under this Program, the following list has been developed as a general reference.

Payment may be made for necessary:

- medical care provided by qualified physicians, nurses, optometrists, and other practitioners within the scope of their practice as defined by State Law;
- preventive, prophylactic and other routine dental care services and supplies provided by dentists and others professional dental personnel;
- inpatient care in hospitals, skilled nursing facilities, infirmaries, other eligible medical institutions (except that inpatient care is not covered for individuals from age 21 to 65 in institutions primarily or exclusively for the treatment of mental illness or tuberculosis), and health related care in intermediate care facilities;
- outpatient hospital and clinic services;
- home health care by approved home health agencies;
- personal care services prior authorized by the LDSS;
- physical therapy, speech pathology and occupational therapy;

- laboratory and X-ray services;
- family planning services;
- prescription drugs per the Commissioner's List, supplies and equipment, eyeglasses, and prosthetic or orthotic devices;
- early and periodic screening, diagnosis and treatment for individuals under 21;
- transportation when essential to obtain medical care;
- care and services furnished by qualified health care organizations or plans using the prepayment capitation principle;
- services of podiatrists in private practice only for persons in receipt of Medicare or under age 21 with written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

Providers must offer the same quality of service to Medicaid enrollee that they commonly extend to the general public and may not bill Medicaid for services that are available free-of-charge to the general public.

## Qualified Medicare Beneficiary

The Medicaid Program permits payment toward Medicare deductibles and coinsurance, as appropriate, for certain Medicare Part B services provided to a select group of elderly and disabled Medicare enrollees with low income and very limited assets. These individuals are known as Qualified Medicare Beneficiaries (QMBs).

**Not all Medicaid enrollees who have Medicare Part B coverage are QMBs.**

Entitlement to QMB benefits must be confirmed by accessing the MEVS. It is crucial to note that the mere presentation of the enrollee's CBIC or other appropriate documentation is not sufficient to confirm an individual's entitlement to QMB services. A provider must confirm an individual's current QMB eligibility by accessing the MEVS prior to the provision of each service.

## Free Choice

A person covered under Medicaid is free to choose from among qualified facilities, practitioners and other providers of services who participate in the Medicaid Program.

Enrollment in Medicaid does not mandate practitioners to render services to all Medicaid enrollees who request care. If a private payment arrangement is made with a Medicaid enrollee, the enrollee should be notified in advance of the practitioner's choice

not to accept Medicaid reimbursement. The Medicaid Program cannot be billed for services rendered under these circumstances.

Guidelines that govern reasonable application of "free choice" are:

- Appropriate resources of the local medical market area should first be utilized in order to avoid unnecessary transportation costs;

- Medical "shopping around" habits should be discouraged so that continuity of care may be maintained.

## Right to Refuse Medical Care

Federal and State Laws and Regulations provide for Medicaid enrollees to reject any recommended medical procedure of health care or services and prohibits any coercion to accept such recommended health care. This includes the right to reject care on the grounds of religious beliefs.

## Civil Rights

In structuring their practice, practitioners must ensure that any limitations are based on criteria which are not discriminatory and continue to comply with a person's civil rights.

Public Law 88-352, the Civil Rights Act of 1964 as amended in 1972, Section 601, and Rehabilitation Act of 1973 reads as follows:

> *"No person in the United States shall, on the ground of race, color, national origin, age, sex, religion or handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."*

## Confidentiality

Information, including the identity and medical records of Medicaid enrollees, is considered confidential and cannot be released without the expressed consent of the enrollee. Medical records and information which are transmitted for the purpose of securing medical care and health services are received and held under the same confidentiality.

All providers **must** comply with these confidentiality requirements.

The DOH, its various political subdivisions, LDSS and eMedNY Contractor, must also observe the confidentiality requirements and must provide safeguards against unauthorized disclosure. This policy should in no way be construed to preclude authorized access to records by the DOH which is under a very strict obligation to monitor medical practices under the Medicaid Program. Authorized representatives of

the Department, its subdivisions, LDSS and eMedNY Contractor have the right to clear access to the medical and financial Medicaid records.

This general policy does not preclude the release of information to the eMedNY Contractor, and to Federal, State and local program officials for purposes directly connected with the administration of the Medicaid Program.

## When Medicaid Enrollees Cannot be Billed

This is the policy of the Medicaid Program concerning the enrollee, including those Medicaid enrollees who are enrolled in a Managed Care Plan and in Family Health Plus.

### Acceptance and Agreement

When a provider accepts a Medicaid enrollee as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid Managed Care enrollee, agrees to bill the enrollee's Managed Care Plan for services covered by the contract. The provider is prohibited from requesting any monetary compensation from the enrollee, or his/her responsible relative, except for any applicable Medicaid co-payments.

**Private Pay Agreement**
A provider may charge a Medicaid enrollee, including a Medicaid enrollee enrolled in a Managed Care Plan, **ONLY** when both parties have agreed **PRIOR** to the rendering of the service that the enrollee is being seen as a private-pay patient. This must be a mutual and voluntary agreement. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A provider who participates in Medicaid fee-for-service but does not participate in the enrollee's Medicaid Managed Care Plan may not bill Medicaid fee-for-service for any services that are included in the Managed Care Plan, with the exception of family planning services. Neither may such a provider bill the enrollee for services that are covered by the enrollee's Medicaid Managed Care contract unless there is a prior agreement with the enrollee that he/she is being seen as a private patient as described above. The provider must inform the enrollee that the services may be obtained at no cost to the enrollee from a provider that participates in the enrollee's Managed Care Plan.

### Claim Submission

The prohibition on charging a Medicaid enrollee applies when a participating Medicaid provider fails to submit a claim to the Department's eMedNY Contractor, Computer Sciences Corporation (CSC), or the enrollee's Managed Care Plan within the required timeframe. It also applies when a claim is submitted to CSC or the enrollee's Managed Care Plan and the claim is denied for reasons other than that the patient was not Medicaid-eligible on the date of service.

## Collections

A Medicaid enrollee, including a Medicaid Managed Care Enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, except for applicable Medicaid co-payments, when the provider has accepted the enrollee as a Medicaid patient. Providers may use any legal means to collect applicable unpaid Medicaid co-payments.

## Emergency Medical Care

A hospital that accepts a Medicaid enrollee as a patient, including a Medicaid enrollee enrolled in a Managed Care Plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established co-payments, a Medicaid enrollee should never be required to bear any out-of-pocket expenses for medically-necessary inpatient services or medically-necessary services provided in a hospital-based emergency room (ER). This policy applies regardless of whether the individual practitioner treating the enrollee in the facility is enrolled in the Medicaid Program.

When reimbursing for ER services provided to Medicaid enrollees in Managed Care, health plans must apply the *Prudent Layperson Standard*, provisions of the Medicaid Managed Care Model Contract and Department directives.

## Claiming Problems

If a problem arises with a claim submission, the provider must first contact CSC or, if the claim is for a service included in the Medicaid Managed Care benefit package, the enrollee's Medicaid Managed Care plan.

If CSC or the Managed Care Plan is unable to resolve an issue because some action must be taken by the enrollee's LDSS (i.e., investigation of enrollee eligibility issues), then the provider must contact the LDSS for resolution.

## Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Prior Approval determinations are made by the Local Professional Director for the district having financial responsibility for the enrollee (which is identified via MEVS). It is the providers' responsibility to verify whether the services and care rendered in their professional areas require prior approval.

Prior Approval contacts can be contacted at the telephone numbers listed in the Information for All Providers, Inquiry Manual, online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

When a provider determined that a service requires prior approval, he/she must obtain a prior approval number by following procedures outlined in the Billing Guidelines and Policy Guidelines sections of each provider manual. Requests for prior approval must be submitted before a service is rendered, except in cases of emergency.

## Prior Approval and Payment

No payment will be made when the request for prior approval is submitted after the service is rendered, except in cases of emergency.

**Prior approval does not ensure payment.** Even when a service has been prior approved, the provider must verify an enrollee's eligibility via the MEVS before the service is provided and comply with all other service delivery and claims submission requirements described in each related section of the provider manual.

Services for which the provider has received prior approval are not subject to Utilization Thresholds.

On the appropriate claim form, the provider must include the prior approval number assigned to his/her request. Information on the claim form must be consistent with the information given and received during the prior approval process.

When a treatment plan has been prior approved for an enrollee, and that enrollee becomes ineligible before the plan is completed, payment for services provided outside the enrollee's eligibility period shall not be made except where:

- the enrollee is enrolled in the Physically Handicapped Children's Program and has an approved treatment plan; or
- failure to pay for services would result in undue hardship to the patient.

When a provider's treatment plan for an enrollee has been prior approved, but the provider becomes ineligible to participate in the Medicaid Program before that plan is completed, payment for services remaining to be provided will not be made unless undue hardship is placed on the enrollee.

When the reason for ineligibility is due to the provider's suspension or disqualification due to improper practices, under no circumstances will services by that provider be paid after the termination date. All efforts will be made by the LDSS to secure a new provider for the enrollee so the plan can be re-evaluated and, where indicated, completed.

Approval will not be given for providers to render services they are not ordinarily qualified to render. In the event such services are provided by a practitioner in the case of an emergency, the provider must attach to the claim form a justification of the services rendered and complete the "SA EXCP CODE" and "EMERGENCY" fields on the claim. Please refer to the Billing Guidelines section of your specific provider manual.

When a fee, rate or price change takes place on a prior approved service, the fee, rate or price in effect at the time the service is rendered must be submitted by the provider on the claim for that service.

When prior approval is granted for services to be rendered by a specific date, any extension of such services beyond the time granted must be submitted on a new prior approval request outlining a new or modified treatment plan. Additionally, should a change be necessary in an approved course of treatment, a new Prior Approval Request must be submitted.

## Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

**Prior authorization does not ensure payment. Even if a service has been prior authorized, the provider still must verify an enrollee's eligibility via the MEVS before rendering service and the claim must be otherwise payable in accordance with the requirements as found in each related section of the provider manual.**

In instances when a prior authorized item or service has been ordered, the vendor must confirm that the orderer has not been excluded from the Medicaid Program.

There are certain services which always require prior authorization, i.e., personal care services and non-emergency transportation. Each specific provider manual indicates which services, if any, require prior authorization. Services requiring prior authorization are not subject to Utilization Thresholds.

## Utilization of Insurance Benefits

The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payments have been exhausted; Medicaid is the payer of last resort.

The Medicaid Program does not require providers to enroll as Medicare providers, with few exceptions (i.e., skilled nursing facilities, general hospitals, clinics, and ambulance companies) and are not required to enter into a contract with all other payers simply because Medicaid requires providers to exhaust all existing benefits prior to the billing of

the Medicaid Program. However, if providers do not enter into an agreement with other payers (excluding Medicare), then they must follow the instructions and requirements contained in Title 18 Section 542 of New York State Code of Rules and Regulations. These guidelines are searchable online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

If an enrollee has third-party insurance coverage, he/she is required to inform the LDSS of that coverage and to use its benefits to the fullest extent before using Medicaid. Supplementary payments may be made by Medicaid when appropriate.

Upon verification of an enrollee's eligibility via MEVS, information specific to an enrollee's eligibility is reported. Eligibility verification responses are detailed in the **MEVS Manual** and Third Party Insurance codes are available in the Third Party Information Manual online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

## Fair Hearing

If either the provider or enrollee feels that a service which has been recommended by the provider has been unjustifiably denied, the enrollee may request a Fair Hearing via any one of the following methods:

- Call (800) 342-3334, or
- Fax a copy of the denial notice to (518) 473-6735, or
- Online at http://www.otda.state.ny.us/oah/forms.asp; or
- In writing to:

Disability Assistance
P.O. Box 1930
Albany, New York, 12201.

## Billing

Providers must bill all applicable insurance sources before submitting claims to Medicaid. Payment from those sources must be received before submitting a Medicaid claim.

Medicaid providers may not refuse to furnish services to an individual eligible to receive such services because of a third party's liability for payment for the service.

Third party insurers and corresponding coverage codes for a Medicaid-eligible enrollee can be found online in the **Information for All Providers, Third Party Information Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

## Record Keeping

Providers must maintain appropriate financial records supporting their determination of available resources, collection efforts, receipt of funds and application of monies received. Such records must be readily accessible to authorized officials for audit purposes.

# Section II – Provider Information

The State of New York requires that all providers who participate in the Medicaid Program meet certain basic criteria. For most, this involves the possession of a license or operating certificate and current registration. Compliance with these basic standards is essential not only for medical institutions and facilities, but for professional practitioners as well.

In order to participate in the Medicaid Program, providers are required to enroll with the DOH. For provider enrollment contact information, please refer to the **Information for All Providers, Inquiry Manual**, available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Providers must inform DOH of any changes in their status as an enrolled provider in the Medicaid Program, i.e., change of address, change in specialty, change of ownership or control. Provider maintenance forms are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

## Enrollment of Providers

Every person who furnishes care, services or supplies and who wishes to receive payment under the Medicaid Program must enroll as a provider of services prior to being eligible to receive such payments.

Continued participation in the Medicaid Program by providers is subject to re-enrollment upon notice by the Department.

## Applications for Enrollment/Re-enrollment

Upon receipt of an application for enrollment or re-enrollment, the Department will conduct an investigation to verify or supplement information contained in the application. The Department may request further information from an applicant and may review the background and qualifications of an applicant.

The Department will complete its investigation within ninety days of receipt of the application. If the applicant cannot be fully evaluated within ninety days, the Department may extend the time for acting on the application for up to 120 days from receipt of the application.

## Denial of an Application

In determining whether to contract with an applicant, the Department will consider a variety of factors as they pertain to the applicant or anyone affiliated with the applicant. These factors include, but are not limited to, the following:

- Any false representation or omission of a material fact in making the application;
- Any previous or current exclusion or involuntary withdrawal from participation in the Medicaid Program of any other state of the United States or other governmental or private medical insurance program;
- Any failure to make restitution for a Medicaid or Medicare overpayment;
- Any failure to supply further information after receiving written request;
- Any previous indictment for, or conviction of, any crime relating to the furnishing of, or billing for medical care, services or supplies;
- Any prior finding of having engaged in unacceptable practices;
- Any other factor having a direct bearing on the applicant's ability to provide high-quality medical care, services or supplies or to be fiscally responsible to the Program.

## Review of Denial

If any application is denied, the applicant will be given a written notice which may be effective on the date mailed.

After denial of an application, the applicant may reapply only upon correction of the factors leading to the denial or after two years if the factors relate to the prior conduct of the applicant or an affiliate.

All persons whose applications are denied shall have an opportunity to request reconsideration of such denial. A person who wishes to appeal must submit documentation to the Department which will establish that an error of fact was made in reviewing his or her application.

## Termination of Enrollment

A provider's participation in the Medicaid Program may be terminated by either the provider or the Department upon thirty (30) days written notice to the other without cause. Additionally, the provider's participation in the Medicaid Program may be terminated under the following circumstances:

- When a provider is suspended or excluded from the Medicaid Program;
- When a provider's license to practice his or her profession, or any registration or certification required to provide medical care services or supplies has been terminated, revoked or suspended, or is found to be otherwise out of compliance with local or State requirements;
- When a provider fails to maintain an up-to-date disclosure form;
- When a provider's ownership or control has substantially changed since acceptance of his/her enrollment application;
- When at any time, the Department discovers that the provider submitted incorrect, inaccurate or incomplete information on his/her application where provision of correct, accurate or complete information would have resulted in a denial of the application.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Duties of the Provider

By enrolling in the Medicaid Program, a provider agrees to:

- prepare and maintain contemporaneous records as required by Department regulations and law;
- notify the Department, *in writing*, of any change in Correspondence, Pay-To or Service Addresses;
- comply with the disclosure requirements of the Department with respect to ownership and controlling interests, significant business transactions and involvement with convicted persons;
- report any change in the ownership or control or a change of managing employees to the Department within fifteen (15) days of the change;
- accept payment under the Medicaid Program as payment in full for the services rendered;
- submit claims for payment for services actually furnished, medically necessary and provided to eligible persons;

- permit audits of all books and records or a sample thereof relating to services furnished and payments received under the Medicaid Program;

- comply with the rules, regulations and official directives of the Department.

## Keeping Current with Policy Information

Policy information is relayed through the monthly *Medicaid Update* newsletter, which is available in hard copy and electronically; and is sent automatically to each enrolled Medicaid provider. The *Medicaid Update* is available online at:

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm.

Providers are responsible to check their Provider Manual on a *monthly basis* to ensure they are current with the latest policy information. This includes the Information for All Providers sections, which contain general Medicaid policy, general billing, inquiry and third party insurance information.

Hard copies of Provider Manuals are available for those providers who do not have access to the Internet. In these cases, the provider must call Computer Sciences Corporation at:

(800) 343-9000.

## Change of Address

It is the responsibility of the provider to notify the Medicaid Program of any change in address. Keeping the provider file current will ensure the provider receives all updates and announcements. "Change of Address" forms for Rate-Based or Fee-for-Service providers are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

## Out-of-State Medical Care and Services

Out-of-State providers must enroll in the New York State Medicaid Program in order to be reimbursed by the Program. Enrollment contact information is available in the **Information for All Providers - Inquiry Manual** at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Medicaid-eligible individuals normally obtain medical care and services from qualified providers located in New York State. An enrolled out-of-state provider will be reimbursed for services rendered to a New York State Medicaid enrollee only under the following circumstances:

- The provider practices within the "common medical marketing area" of the enrollee's home LDSS as determined by the Local Professional Director;

- An emergency requires that the out-of-state provider render immediate care to an enrollee who is temporarily out-of-state.

**Under any of these circumstances, only providers in the United States, Canada, Puerto Rico, Guam, the American Virgin Islands, and American Samoa will be reimbursed for care provided to New York State Medicaid enrollees.**

## Non-Emergent Inpatient Care

The Medicaid Program provides assistance in the form of payment to enrolled, qualified out-of-state inpatient services providers when the best interest of the applicant or enrollee will be most effectively served because of his/her social situation or when the inpatient care is needed by a patient, as determined in the basis of medical advice, is more readily available in the other state.

A qualified out-of-state provider is normally a facility recognized by their home state as a Medicaid Program inpatient facility services provider (i.e., a hospital, skilled nursing or intermediate care facility, residential treatment center, etc.).

A Medicaid prior approval for the placement of a New York State Medicaid enrollee with an out-of-state medical inpatient facility is required to document that the needed services are not readily available within the State of New York. Approval is based upon a determination made by the Department of Health. Prior approval and medical review contacts are listed in the **Information for All Providers – Inquiry Manual** online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

Where a mentally disabled enrollee is seeking out-of-state care, approval is subject to the approval of the State office that provides services to this patient population within New York State, either the Office of Mental Health or Mental Retardation and Developmental Disabilities.

## Prior Approval

For out-of-state services provided in situations other than those noted above, prior approval must be obtained for all services. For services provided in those situations noted above, prior approval requirements will be identical to those mandated for in-state providers.

## Billing Procedures

Out-of-state providers enrolled in the Program will follow the regular billing procedures for Medicaid.

## Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. Providers must furnish information regarding any payment claim to authorized officials upon request of the DOH or the LDSS.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records. Practitioners providing diagnostic and treatment services must keep medical records on each enrollee to whom care is rendered. At a minimum, the contents of the enrollee's hospital record should include:

- enrollee information (name, sex, age, etc.);
- conditions or reasons for which care is provided;
- nature and extent of services provided;
- type of services ordered or recommended for the enrollee to be provided by another practitioner or facility;
- the dates of service provided and ordered.

The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program.

For auditing purposes, records on enrollees must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

## General Exclusions from Coverage Under Medicaid

In an effort to assure quality care and to contain costs under the Medicaid Program, certain restrictions have been placed on Medicaid payments to providers. As a general reference, the following list of medical care and services which do not qualify for payment is presented.

Payment will **not** be made for medical care and services:

- Which are medically unnecessary;

- Whose necessity is not evident from documentation in the enrollee's medical record;
- Which fail to meet existing standards of professional practice, are currently professionally unacceptable, or are investigational or experimental in nature;
- Which are rendered outside of the enrollee's period of eligibility;
- Which were not rendered, ordered, or referred by a restricted enrollee's primary care provider unless the service was provided in an emergency, was a methadone maintenance claim or a service provided in an inpatient setting;
- When the claim was initially received by the Department more than ninety days after the original date of service (refer to the Information for All Providers, General Billing Manual for exceptions);
- Which require prior approval or authorization, but for which such approval/authorization was not obtained or was denied;
- For which third parties (i.e., Medicare, Blue Cross/Blue Shield) are liable;
- Which are rendered out-of-state but which do not meet the qualifications outlined in the section Out-of-State Medical Care and Services;
- Which are fraudulently claimed;
- Which represent abuse or overuse;
- Which are for cosmetic purposes and are provided only because of the enrollee's personal preference;
- Which are rendered in the absence of authorization from the MEVS in accordance with Utilization Threshold requirements. Exceptions to this policy include instances when a provider uses one of the Service Authorization Exception codes on the claim. Details are found in the **Billing Guidelines** section of each specific provider manual.
- Which have already been rejected or disallowed by Medicare when the rejection was based upon findings that the services or supplies provided:
    - Were not medically necessary;
    - Were fraudulently claimed;
    - Represented abuse or overuse;
    - Were inappropriate;

- Were for cosmetic purposes; or
- Were provided for personal comfort.

➢ Which are rendered after an enrollee has reached the Utilization Threshold established for a specific provider service type unless one of the following conditions is satisfied:

- The enrollee has been exempted from the Utilization Threshold;
- The enrollee has been granted an increase in the Utilization Threshold;
- The provider certifies that the care, services or supplies were furnished pursuant to a medical emergency or when urgent medical care was necessary.

## Unacceptable Practices

Examples of unacceptable practices include, but are not limited to, the following:

➢ Knowingly making a claim for an improper amount or for unfurnished, inappropriate or unnecessary care, services or supplies;

➢ Ordering or furnishing inappropriate, improper, unnecessary or excessive care, services or supplies;

➢ Billing for an item/service prior to being furnished;

➢ Practicing a profession fraudulently beyond its authorized scope, including the rendering of care, services or supplies while one's license to practice is suspended or revoked;

➢ Failing to maintain or make available for purposes of audit or investigation records necessary to fully disclose the extent of the care, services or supplies furnished;

➢ Submitting bills or accepting payment for care, services or supplies rendered by a person suspended or disqualified from practicing in the Medicaid Program;

➢ Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Medicaid enrollee to either utilize or refrain from utilizing any particular source of care, services or supplies;

➢ Knowingly demanding or collecting any compensation in addition to claims made under the Medicaid Program, except where permitted by law;

- Denying services to an enrollee based upon the enrollee's inability to pay a co-payment; and

- Failure to use the POS Terminal for verification, post and/or clear procedures when designated to do so.

## Process for Resolving Unacceptable Practices

If the Department proposes to sanction a person, the DOH will advise that person, in writing, of the following:

- The unacceptable practice with which the person has been charged;

- The administrative action which is proposed (i.e., exclusion, or censure, and its statutory, regulatory or legal basis);

- The person's right to submit documentation or written arguments against the proposed agency action within 30 days from the date of the notice of proposed action.

## Affiliated Persons

Whenever the Department sanctions a person, it may also sanction any affiliate of that person. Affiliated persons will be sanctioned on a case-by-case basis with due regard to all the relevant facts and circumstances leading to the original sanction.

> Affiliated persons are those individuals having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under a common control.

Some examples of affiliated persons are the following:

- persons with an ownership or controlling interest in a provider;

- agents and managing employees of a provider;

- providers who share common managing employees;

- subcontractors with whom the provider has more than $25,000 in annual business transactions.

## Agency Action

If the Department determines to sanction a person, it will send a written notice of agency action advising the person of the final determination at least 20 days before the action becomes effective.

## Suspension or Withholding of Payments

Upon notification to the person that he/she has engaged in an unacceptable practice, payment to that person may be withheld for current and subsequently received claims, or all payments may be suspended pending a resolution of the charges.

## Hearings

A person has the right to a hearing to review a determination that he/she has engaged in an unacceptable practice. All requests for hearings must be in writing and must be made within sixty days of the date of the notice of agency action notifying the person of the unacceptable practice.

In the even that a person withdraws or abandons his/her request for a hearing, the hearing will be cancelled.

A request for a hearing will not defer any administrative action. All hearings will be conducted in accordance with the procedures contained in Part 519 of Title 18 of the Official Codes, Rules and Regulations of the State of New York which can be found by conducting a search online at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Administrative Sanctions

When it is determined that a person has been engaged in unacceptable practices, the DOH may take one or more of the following sanctions:

- The person may be excluded from participation in the Medicaid Program. No payments will be made to a person who is excluded from the Medicaid Program for care, services or supplies rendered to enrollees as of the date of his/her exclusion;

- No payments will be made for any medical care, services or supplies ordered by a person who is excluded or suspended from the Medicaid Program;

- The person may be censured in writing with notification to the appropriate governmental licensing and/or regulatory agencies.

A sanction designed to monitor the Program activities of a person may be imposed against anyone who has been previously suspended from the Medicaid Program or as a precondition to a person's continued participation of the Program. Such sanctions include:

- Requiring, prior to payment, a review of any care, services or supplies rendered by the person; or

- Requiring prior approval for all care, services or supplies to be rendered by the person.

The DOH may also choose to impose fiscal sanctions against persons who engage in unacceptable practices. Examples of fiscal sanctions include:

- Restitution plus interest may be collected from a person who has received payment for care, services or supplies associated with an unacceptable practice; or

- Reduction in payment may be utilized when it is determined that the person has rendered care, services or supplies not included in the scope of the Program, or that the person has billed for more costly care, services or supplies that were actually provided; or

- Payment may be denied to a person who has engaged in an unacceptable practice.

## Guidelines for Sanctions

In determining the sanction to be imposed, the following factors will be considered:

- The number and nature of the Program violations or other related offenses;

- The nature and extent of any adverse impact the violations have had on enrollees;

- The amount of damages to the Program;

- Mitigating circumstances;

- Other facts related to the nature and seriousness of the violations; and

- The previous record of the person under the Medicare Program, the Medicaid Program and other Social Services Programs.

## Immediate Sanctions

In the following cases, a person may be immediately sanctioned on five (5) days notice:

- When a person or an affiliate is suspended from the Medicare Program the person will be suspended from the Medicaid Program for a period of time at least equal to the period of suspension from the Medicare Program;

- When a person has been convicted of any crime relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been charged with a felony offense relating to the rendering of, or billing for medical care, services or supplies;

- When a person has been the subject of administrative, judicial proceeding finding the person to have committed unprofessional misconduct or an act which would constitute an unacceptable practice under the Medicaid Program; or

- When a person's further participation in the Medicaid Program will endanger the public health, or the health, safety or welfare of any enrollee.

A person sanctioned in these cases will not be entitled to an administrative hearing under the Department's regulations. However, within 30 days of being notified of any immediate sanction, a person may submit written material to challenge any mistake of fact or the appropriateness of a sanction.

## Reinstatement

A person who is sanctioned may request reinstatement, or removal of any condition or limitation on participation in the Medicaid Program, at any time after the date or time period specified in the notice of agency action, or upon the occurrence of an event specified in the notice.

A request for reinstatement or removal of any condition on participation in the Program is made as an application for enrollment under Part 504 of the Department's regulations and must be denominated as a request for reinstatement to distinguish it from an original application.

The request for reinstatement must be sent to the Enrollment Processing Unit of the Department, and must:

- Include a complete ownership and control disclosure statement;

- State whether the person has been convicted of other offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction; and

- State whether any State or local licensing authorities have taken any adverse action against the person for offenses related to participation in the Medicare Program, the Medicaid Program or other Social Services Programs which were not considered during the development of the sanction.

For a more extensive and precise definition of his/her rights and obligations, persons are referred to part 504, 515, 517, 518 and 519 of Title 18 of the New York Code of Rules and Regulations which are found by doing a search at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Audits

The DOH is responsible for monitoring the Medicaid Program in New York State. This includes evaluating whether providers of medical care, services and supplies are in compliance with applicable State and Federal law and regulations.

The Department conducts audits of persons who submit claims for payment under the Medicaid Program, and the Department may seek recovery or restitution if payments were improperly claimed, regardless of whether unacceptable practices have occurred. The Department may either conduct an on-site field audit of a person's records or it may conduct an in-house review utilizing data processing procedures.

If overpayments are found, the Department will issue a draft audit report which will set forth any items to be disallowed and advise the person of the Department's proposed action. The person will then have 30 days to submit documents in response to the draft and/or object to any proposed action.

After considering the person's submittal, if any, the Department will issue a final audit report advising the person of the Department's final determination. The person may then request an administrative hearing to contest any adverse determination.

### Recovery of Overpayments

When any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount overpaid.

An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

### Recoupment

Overpayments may be recovered by withholding all or part of a person's and an affiliate's payments otherwise payable, at the option of the Department.

### Withholding of Payments

The Department may withhold payments in the absence of a final audit report when it has reliable information that a person is involved in fraud or willful misrepresentation

involving claims submitted to the Program, has abused the Program or committed an unacceptable practice. Reliable information may consist of:

- Preliminary findings of unacceptable practices or significant overpayments;
- Information from a State professional licensing or certifying agency of an ongoing investigation of a person involving fraud, abuse, professional misconduct or unprofessional conduct; or
- Information from a State investigating or prosecutorial agency or other law enforcement agency of an ongoing investigation of a person for fraud or criminal conduct involving the Program.

Notice of the withholding will usually be given within five days of the withholding of payments. The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation.

The withholding may continue as follows:

- If payments are withheld prior to issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written draft report or notice of proposed agency action is sent to the provider.
    - Issuance of the draft report or notice of proposed agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- If payments are withheld after issuance of a draft report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written final audit report or notice of agency action is sent to the provider.
    - Issuance of the report or notice of agency action may extend the duration of the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
- When initiated by another State agency or law enforcement organization, the withholding may continue until the agency or prosecuting authority determines that there is insufficient evidence to support an action against the person, or until the agency action or criminal proceedings are completed.

## Fraud

Examples of fraud include when a person knowingly:

- makes a false statement or representation which enables any person to obtain medical assistance to which he/she is not entitled;
- presents for allowance of payment any false claim for furnishing services or merchandise;
- submits false information for the purpose of obtaining greater compensation than that to which he/she is legally entitled; or
- submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

## Office of the Medicaid Inspector General

The Office of the Medicaid Inspector General (OMIG) is an independent fraud-fighting entity within the Department of Health whose functions include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, to the greatest extent possible, coordinating such activities amongst:
    - the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services;
    - the Department of Education;
    - the eMedNY Contractor, Computer Sciences Corporation (CSC), employed to operate the Medicaid Management Information System;
    - the State Attorney General for Medicaid Fraud Control; and,
    - the State Comptroller;
- pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or other illegal or inappropriate acts perpetrated against the Medicaid Program;
- keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid Program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;
- making information and evidence relating to potential criminal acts which we may obtain in carrying out our duties available to appropriate law enforcement and consulting with:
    - the New York State Deputy Attorney General for Medicaid Fraud Control;

  - federal prosecutors; and
  - local district attorneys to coordinate criminal investigations and prosecutions;

- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse; and
- performing any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office.

The OMIG also has broad subpoena powers:

- *ad testificandum* (a subpoena *ad testificandum* is a command to a named individual or corporation to appear at a specified time and place to give oral testimony under oath); and
- *duces tecum* (i.e., a writ or process of the same kind as the *subpoena ad testificandum,* including a clause requiring the witness to bring with him and produce to the court, books, papers, etc.).

The Medicaid Inspector General is headquartered in Albany with regional field offices in New York City, White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

For more information, please refer to the OMIG website:

www.omig.state.ny.us.

The OMIG website contains:

- An online complaint reporting mechanism;
- Current comprehensive listing of banned Medicaid providers;
- Significant news of OMIG initiatives and actions; and
- Useful links to State and federal resources in the Medicaid field.

## Prohibition Against Reassignment of Claims: Factoring

The practice of factoring is prohibited by Federal Medicaid Regulations, which specify that no payment for any care or service provided to a Medicaid enrollee can be made to anyone other than the provider of the service.

Payment shall not be made to or through a factor either directly or by use of a power of attorney given by the provider to the factor.

## Exceptions

Exceptions to the prohibition against the reassignment of Medicaid claims are allowed under the following circumstances:

- Direct payment for care or services provided to a Medicaid enrollee by physicians, dentists or other individual practitioners may be made to:
    - The employer (Article 28 facility, or other medical providers certified by State agencies) of the practitioner, if the practitioner is required to turn over fees to his/her employer as a condition of employment;
    - The facility in which the care or service was provided, if there is an arrangement whereby the facility submits the claim for other affiliated persons in its claim for reimbursement;
    - A foundation, plan, or similar organization, including a health maintenance organization which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the practitioner furnishing the service under which the organization bills or receives payments on a basis other than a percentage of the Medicaid payments for such practitioner's services.
- Payments are allowed which result from an assignment made pursuant to a court order;
- Payments may be made to a government agency in accordance with an assignment against a provider;
- Payment may be made to a business agent, such as a billing service or accounting firm, that prepares statements and receives payments in the name of a provider, if the business agent's compensation for the service is:
    - Reasonably related to the cost of services;
    - Unrelated, directly or indirectly, to the dollar amounts billed and collected; and
    - Not dependent upon the actual collection of payment.

## Services Subject to Co-Payments

The following services are subject to a co-payment:

- Clinic Visits (Hospital-Based and Free-Standing Article 28 Health Department-certified facilities) - $3.00;

- Laboratory Tests performed by an independent clinical laboratory or any hospital-based/free-standing clinic laboratory - $0.50 per procedure;
- X-rays performed in hospital clinics, free-standing clinics -$1.00 per procedure;
- Medical Supplies including syringes, bandages, gloves, sterile irrigation solutions, incontinence pads, ostomy bags, heating pads, hearing aid batteries, nutritional supplements, etc. - $1.00 per claim;
- Inpatient Hospital Stays (involving at least one overnight stay – is due upon discharge) - $25.00;
- Emergency Room – for non-urgent or non-emergency services - $3.00 per visit;
- Pharmacy Prescription Drugs - $3.00 Brand Name, $1.00 Generic;
- Non-Prescription (over-the-counter) Drugs - $0.50.

There is no co-payment on private practicing physician services (including laboratory and/or X-ray services, home health services, personal care services or long term home health care services.

## Co-payment Maximum

The annual co-payment maximum per enrollee per state fiscal year (April 1 through March 31) is $200.

## Co-payment Exemptions

The following are exempt from all Medicaid co-payments:

- Enrollees younger than 21 years old.
- Enrollees who are pregnant.
    - Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Family planning (birth control) services.
    - This includes family planning drugs or supplies like birth control pills and condoms.
- Residents of an Adult Care Facility licensed by the New York State Department of Health (**for pharmacy services only**).

- Residents of a Nursing Home.
    - Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- Residents of an Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD) certified Community Residence.
- Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program.
    - Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program.
- Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Enrollees in a Care plan.

Enrollees who are eligible for both Medicare and Medicaid and/or receive Supplemental Security Income (SSI) payments *are not exempt* from Medicaid co-payments, unless they also fall into one of the groups listed above. Enrollees cannot be denied care and services because of their inability to pay the co-payment amount.

The potential provider of a service will be required to access the MEVS to enter the applicable co-payment amount, if any is due for the service being provided. When accessing the MEVS, the provider will be given information as to the enrollee's exemption status for co-payments. Specific instructions on the MEVS information obtained by the provider may be found in the MEVS manual.

# Section III – Ordering Non-Emergency Medical Transportation

A request for prior authorization of non-emergency medical transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

**Any order practitioner or facilities/programs ordering on the practitioner's behalf, which do not meet the rules of this section, may be sanctioned according to the regulations established by the Department of Health at Title 18 Section 515.3, available online at:**

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Responsibilities of the Ordering Practitioner

Ordering practitioners are responsible for ordering only necessary transportation at the medically appropriate level. A basic consideration for this should be the enrollee's current level of mobility and functional independence.

The transportation ordered should be the least specialized mode required based upon the enrollee's *current* medical condition. For example, if the orderer feels the enrollee does not require personal assistance, but cannot walk to public transportation, then livery service should be requested.

Enrollees who have reasonable access to a mode of transportation used for the normal activities of daily living; such as shopping and recreational events; are expected to use

this mode to travel to and from medical appointments when that mode is available to them. For most residents of New York City, this mode is usually mass transit.

Medicaid may restrict payment for transportation if it is determined that:

- the enrollee chose to go to a medical provider outside the CMMA when services were available within the CMMA;
- the enrollee could have taken a less expensive form of transportation but opted to take the more costly transportation.

In either case above, if the enrollee can demonstrate circumstances justifying payment, then reimbursement can be *considered*.

## Non-emergency Ambulance

Generally, ambulance service is requested when a Medicaid enrollee needs to be transported in a recumbent position or is in need of medical attention while en route to their medical appointments.

A request for prior authorization of non-emergency ambulance services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant; or
- Nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation on behalf of the ordering practitioner.

## Ambulette

Ambulette service is door-to-door; from the enrollee's home through the door at the building where the medical appointment is to take place. Personal assistance by the staff of the ambulette company is required by the Medicaid Program in order to bill the Program for the provision of ambulette service.

> **If personal assistance is not necessary and/or not provided, then livery service should be ordered.**

Ambulettes may also provide taxi (curb-to-curb) service and will transport livery-eligible enrollees in the same vehicle as ambulette-eligible enrollees. The Medicaid Program

does not require the ambulette service to be licensed as a taxi service; but the ambulette must maintain the proper authority and license required to operate as an ambulette.

A request for prior authorization of ambulette transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The Medicaid enrollee needs to be transported in a recumbent position, needs no medical treatment en route to his or her appointment, and the ambulette service is able to accommodate a stretcher;
- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery service, public transportation or a private vehicle;
- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, public transportation or a private vehicle;
- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments which result in a disabling physical condition after treatment, making the enrollee unable to access transportation without personal assistance provided by an ambulette service;

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette services; and,

- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, livery service, bus or private vehicle and there is a need for ambulette service.

**The ordering practitioner must note in the patient's record the condition which qualifies the use of ambulette services.**

## Livery Transportation

A request for prior authorization for transportation by New York City livery services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;

- Physician's assistant;

- Nurse practitioner;

- Dentist;

- Optometrist;

- Podiatrist; or

- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

## Day Treatment Transportation

Day treatment/day program transportation is unique in that this transportation can be provided by an ambulance, ambulette or livery provider. The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

Providers of transportation to day treatment/day program must adhere to the same requirements for their specific provider category.

## Required Documentation

In cases where an ordering practitioner believes that a Medicaid enrollee should use a particular form of non-emergency transportation, Medicaid guidelines at Title 18 of the New York Code of Rules and Regulations Section 505.10 (c)(4) indicate that:

> *"The ordering practitioner must note in the [enrollee's] patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services."*

## Making the Request for Authorization

Requests for medical transportation require the authorization of the local department of social services (DSS). Please refer to the Information for All Providers – Inquiry Manual for telephone numbers of DSS staff.

New York City practitioners and facilities should refer to the Prior Authorization Guidelines manual titled City of New York Transportation Ordering Guidelines, which is available online at:

http://www.emedny.org/ProviderManuals/Transportation/index.html.

# Section IV - Family Planning Services

All Medicaid-eligible persons 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 Medicaid ID Card in their possession. To verify eligibility, the physician or his/her staff should obtain birth date, sex, social security number, or as much of this information as possible, before contacting the Department at:

**(518) 472-1550**.
*If sufficient information is provided,*
*Department staff will verify the eligibility of the individual for Medicaid.*

Medicaid patients enrolled in managed care plans (identified on MEVS as "PCP"), 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. 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 of coercion or mental pressure to use family planning services and 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, nurse practitioner, clinic, or hospital, which complies with all applicable provisions of law.

In addition, services are available through designated Family Planning Service Programs, which 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 physician who performs the sterilization must discuss the information below with the patient 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 enrollee 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 enrollee 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 enrollee to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.

## Mental Competence

The patient must be a mentally competent individual.

## Institutionalized Individual

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

## Restrictions on Circumstances in Which Consent is Obtained

Informed consent may not be obtained while the patient 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 patient's state of awareness.

## Foreign Languages

An interpreter must be provided if the patient 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 patient's choice is mandated by New York City Local Law No. 37 of 1977.

## Reaffirmation Statement (NYC Only)

A statement signed by the patient upon admission for sterilization, again acknowledging 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 *NYS Sterilization Consent Form (DSS-3134)* must be given to the patient 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. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

## 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 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, NY 10013**
**(212) 442-1740.**

## Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are performed solely for the purpose of rendering the patient 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 patient is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

The patient or her representative must sign *Part I of the Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)*. The requirement for the patient'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 enrollee 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.

The DSS-3113 documents the receipt of hysterectomy information by the patient or the surgeon's certification of reasons for waiver of that acknowledgement. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

All surgeons, hospitals, clinics and anesthesiologists must submit a copy of the fully completed DSS-3113 when billing for a hysterectomy. Hospitals and Article 28 clinics submitting claims electronically, must maintain a copy of the completed DSS-3113 in their files. This form, in English and in Spanish, is available online at:

http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms.

## 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. 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 enrollees. Payment for elective abortions is funded with 100% New York City funds.

## Obstetrical Services

Obstetrical care includes prenatal care in a physician's office or dispensary, delivery in the home or hospital, 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 physician should see the patient 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.

### Intrapartum Care

Whenever possible, delivery should be performed in a hospital. In addition to these standards, the routine attendance of a qualified anesthesiologist at the time of delivery

is recommended as an important preventive measure in promoting optimum medical care for both mother and infant.

## 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.

# Section V – Related Programs

## Child/Teen Health Program

New York State's Medicaid Program (Child Health Plus A) implements federal EPSDT requirements via the Child/Teen Health Program (CTHP). The CTHP care standards and periodicity schedule are provided by the Department of Health, and generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics.

New York State's CTHP promotes early and periodic screening, diagnosis and treatment aimed at addressing any health or mental health problems identified during exams. The CTHP includes a full range of comprehensive, primary health care services for Medicaid-eligible youth from birth until age 21.

Many categories of providers directly render or contract for primary health care services for Medicaid-eligible youth services by the CTHP. For example:

- Physicians;
- Nurse Practitioners;
- Clinics;
- Hospitals;
- Nursing Homes;
- Office of Mental Health Licensed Residential Treatment Facilities;
- Office of Mental Retardation and Developmental Disabilities, Licensed Intermediate Care Facilities for the Developmentally Disabled;
- Office of Children and Family Services Authorized Child (Foster) Care Agencies;
- Medicaid Managed Care Organizations; and
- Medicaid-enrolled School-Based Health Centers.

New York State's EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) also emphasizes recommendations of *Bright Futures* in order to guide provider practice, and improve health and mental health outcomes for Medicaid-eligible youth. The EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) is available online at:

http://www.emedny.org/ProviderManuals/EPSDTCTHP/index.html.

## Preferred Physicians and Children Program

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

- 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 and other physician specialists.

## Application for the Preferred Physicians and Children Program

PPAC provider enrollment applications may be obtained online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

PPAC Procedure Codes are in the Procedure Code and Fee Schedule Section of this manual, available at:

http://www.emedny.org/ProviderManuals/Physician/index.html.

## Physician Eligibility and Practice Requirements

The qualified primary care physician will:

- Have an active hospital admitting privilege at an accredited hospital.

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one due to such reason as the unavailability of admitting privilege at area hospitals; or nearest hospital too distant from office to be practical.

  Such physician will submit *each of the following* at the time of application:

  - a description of the circumstance that merits consideration of waiver of this requirement,
  - evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and

- a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics.

  The physician who participates in the PPAC program and is board admissible must re-qualify when board admissibility reaches five years.

- 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 which refers 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.

- Agree to provide periodic health assessment examination in accordance with the Child/Teen Health program (CTHP) standards of Medicaid.

- 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 specialist physician will:

- Have an active hospital admitting privilege at an accredited hospital;

  This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one because the practice of his/her specialty does not support need for admitting privilege.

  Such physician will submit at the time of application, (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) where applicable, **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a

primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- Be board certified (or board admissible for a period of not more than five years from completion of a post graduate training program) in a specialty recognized by the DOH;

  The physician who participates in PPAC and is board admissible must requalify when board admissibility reaches five years.

- 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 agreement to be subject to cancellation with 30-day notice by either party.

## Covered Services

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

The PPAC participating provider may NOT bill for:

- physician services provided in Article 28 clinics or

- contractual physician services in emergency rooms.

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.

## Physically Handicapped Children's Program

The Physically Handicapped Children's Program (PHCP) is a Federal Grant Program under the Social Security Act established to aid states in the provision of medical services for the treatment and rehabilitation of physically handicapped children. Administration of the Program is supervised by Department of Health.

On the local level, county health commissioners, county directors of PHCP, or the New York City Health Department's Bureau of Handicapped Children have responsibility for the Program. Providers will deal primarily with designated local officials.

## Services Available and Conditions Covered

Medical services available under PHCP include diagnostic, therapeutic, and rehabilitative care by medical and paramedical personnel. Necessary hospital and related care, drugs, prosthesis, appliances, and equipment are also available under the Program.

This Program includes care for 125 categories of handicapping conditions. Care is available not only for defects and disabilities of the musculo-skeletal system, but also:

- cardiac defects,
- hearing loss,
- hydrocephalus,
- convulsive disorders,
- dento-facial abnormalities, and
- many other conditions.

Treatment for long-term diseases, i.e., cystic fibrosis, muscular dystrophy, rheumatic heart disease, which are likely to result in a handicap in the absence of treatment, is also available.

For more detailed information on covered services, the provider should contact the county health department or the local PHCP office.

## Eligibility

To participate in the PHCP, a child must first be determined medically-eligible, i.e., having one of the defects or disabilities referred to above.

A child under age 21 who, in a physician's professional judgment, may be eligible for the PHCP should be referred to the local medical rehabilitation officer, the county commissioner of health, the local PHCP medical director, or the Bureau of Handicapped Children (New York City) for a determination of the child's eligibility for the Program.

## Financing

A great number of PHCP cases will be financed by Medicaid. If the family of a medically-eligible child is not currently covered by Medicaid, the family will be referred by PHCP officials to the LDSS for a determination of Medicaid eligibility.

If the child is determined eligible for Medicaid, payment for services for the child will be paid with Medicaid funds. If the child is determined ineligible for Medicaid, payment for services will be paid by the PHCP and/or the child's family.

Reimbursement for services rendered to PHCP participants (either from Medicaid or PHCP funds) will not exceed the fees and rates established by the Department of Health.

## Prior Approval

Prior approval is required for treatment of medical and dental conditions under the Program. Such approval is to assure that:

- The clinical conditions come under the Program;
- The physician or dentist meets the required program qualifications;
- The institution, if necessary, has been specifically approved for the service required.

Prior approval must be obtained from the county health officer or PHCP medical director. Requests for prior approval should be initiated by the attending physician by submission of an appropriate form which may be obtained from city, county, or district health offices, or the eMedNY Contractor.

Prior approval for treatment will be granted only for a specified period of time. Generally, Medicaid reimbursement will only be available for treatment rendered during that approved period of time. Reimbursement, however, will continue to be made should the child's Medicaid coverage be terminated during the treatment period. In such an instance, payment will only be made for the prior-approved treatment and will be discontinued upon completion of that treatment.

In an emergency, care may be provided without prior approval. *However, the county health officer or PHCP medical director must be promptly notified of such care.*

## Family Care Program

The Family Care Program of the New York State Office of Mental Health/Office of Mental Retardation and Developmental Disabilities (OMH/OMRDD) provides supervised residence in the community for inpatients of psychiatric or developmental centers who

have responded to treatment and other persons who, though unable to function adequately in their own homes, do not require inpatient care. Individuals who have been determined able to live in the community may be placed in certified family care homes.

Each family care home must possess an OMH or an OMRDD operating certificate. Those who operate family care homes provide room and board, some non-emergency transportation, and basic support services to their residence. The OMH/OMRDD facility making the placement exercises administrative control over the family care home.

Since the emphasis of the Family Care Program is on integration into the community, the use of private practitioners is encouraged for medical care. Enrollees who have been placed in an approved family care home are eligible for the full range of services covered by Medicaid, except when OMH family-care residents require acute psychiatric hospitalization. These enrollees must return to their psychiatric centers.

State regulations also require annual medical, dental and psychiatric or psychological examinations for all family-care residents, which may be provided by practitioners in the community.

The same prior approval requirements in addition to any other Program restrictions that apply when services are provided to other Medicaid enrollees, also apply in cases involving family care residents.

Individuals in the Family Care Program must be determined Medicaid-eligible by the Department of Health in conjunction with the OMH/OMRDD. Residents determined eligible for Medicaid are issued a permanent plastic CBIC.

## Family Planning Benefit Program

This program provides Medicaid coverage for family planning services to all persons of childbearing age with incomes at or below 200% of the federal poverty level. This population will have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.

Family planning services under this program can be provided by all Medicaid enrolled family planning providers including physicians and nurse practitioners. Covered family planning services include:

- All FDA-approved birth control methods, devices, pharmaceuticals, and supplies;
- Emergency contraceptive services and follow-up;
- Male and female sterilization in accordance with 18 NYCRR Section 505.13(e); and
- Preconception counseling and preventive screening and family planning options.

The following additional services are considered family planning only when provided during a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Counseling services related to pregnancy and informed consent, and STD/HIV risk counseling;
- Comprehensive reproductive health history and physical examination, including clinical breast exam (excluding mammography);
- Screening for STDs, cervical cancer, and genito-urinary infections;
- Screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.;
- HIV counseling and testing;
- Laboratory tests to determine eligibility for contraceptive of choice; and
- Referral for primary care services as indicated.

For more information on the FPBP, please call the Bureau of Policy Development and Coverage at (518) 473-2160.

## Prenatal Care Assistance Program

Prenatal Care Assistance Program (PCAP) is a comprehensive prenatal program administered by the DOH that offers complete pregnancy care and other health services to women and teens who live in New York State and meet certain income guidelines. PCAP offers:

- routine pregnancy check-ups,
- hospital care during pregnancy and delivery,
- full Medicaid coverage for the woman until at least two months after delivery, and
- full Medicaid coverage for the baby up to one year of age.

**Providers** interested in this Program may go online to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

or

http://www.emedny.org/ProviderManuals/Prenatal/index.html.

## Medicaid Obstetrical and Maternal Services Program

Obstetricians, family physicians, nurse midwives and nurse practitioners who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Service (MOMS) program and receive increased fees for obstetrical care.

Practitioners participating in the MOMS program are required to refer Medicaid-eligible pregnant women for non-medical health supportive services such as:

- nutrition and psychosocial assessment and counseling,
- health education, and
- care coordination.

Health supportive services are provided by approved agencies such as county health departments, certified home health agencies and Prenatal Care Assistance Programs (PCAP).

The interested physician, midwife or nurse practitioner may apply to participate in the MOMS program by completing the following two forms, which must be submitted together:

- the "Application for Enrollment as a Medical (or Dental) Specialist" ***and***
- the MOMS Addendum.

For additional information regarding the MOMS and Health Supportive Services programs, please call the Department at:

**(518) 474-1911**.

**MOMS Eligibility and Practice Requirements**
Physicians who participate must:

- be board certified or an active candidate for board certification by the American College of Obstetrics and Gynecologists (ACOG) or eligible for board certification by the American Academy of Family Practice Physicians for a period of no more than five years from completion of a post-graduate training period in obstetrics and gynecology or family practice;
- have active hospital-admitting privileges in an appropriately accredited hospital which includes maternity services;

- provide medical care in accordance with the practice guidelines established by the ACOG;
- have 24-hour telephone coverage;
- have an agreement with an approved health supportive service provider to provide non-medical health supportive services such as health education, nutrition, and psychosocial assessment and counseling, case management, presumptive eligibility, and acting as an authorized representative for the Medicaid application;
- provide medical care coordination and agree to participate in managed care programs if the managed care programs are operational within the physician's geographic practice area;
- be a provider in good standing;
- sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

For physician enrollment information, please go online to:

http://www.emedny.org/info/ProviderEnrollment/index.html

For additional information, please go to:

http://www.health.state.ny.us/nysdoh/perinatal/en/

## Utilization Threshold Program

In order to contain costs while continuing to provide medically necessary care and services, Medicaid will pay for a limited number of certain health services per benefit year unless additional services have been approved. The established thresholds are:

| Service | Number of Visits, Items or Lab Tests Allowed per Year |
|---|---|
| Pharmacy (prescription drugs including initial prescriptions, refills, over-the-counter medicine and medical/surgical supplies) | 40 items if the enrollee is:<br>• Under 21<br>• 65 or over<br>• Certified blind or disabled<br>• Single caretaker of a child under 18<br><br>43 items if the enrollee is: |

| Service | Number of Visits, Items or Lab Tests Allowed per Year |
|---|---|
| | • 21 to 65<br>• Not certified blind or disabled<br>• Not a single caretaker of a child under 18 |
| Physician and Medical Clinic | 10 visits |
| Dental Clinic | 3 visits |
| Laboratory | 18 procedures |
| Mental Health Clinic | 40 visits |

These Utilization Thresholds have been set in accordance with historical information on service use from the Medicaid Program. The threshold limits are high enough so that most enrollees will not be affected. It will be necessary, however, for providers to verify eligibility and to obtain authorization through the MEVS for those services that they provide.

The potential provider of a service will be required to access the MEVS to receive provider/enrollee service data to ascertain whether the enrollee has reached the particular threshold for that type of service. If the enrollee has not reached his/her service limitation, the MEVS will inform the provider that the service is approved and record that approval for transmission to the eMedNY Contractor. Without such approval, the provider's claim for service will not be paid by the eMedNY Contractor. Exceptions to this are situations such as emergency or urgent care when the provider will use on the "SA EXCP CODES" on the claim as described in the **Billing Guidelines** section of each specific provider manual.

The Department recognizes that an initiative such as this must be sensitive to the needs of individual patients who require medically necessary services beyond the normal limits because of a chronic medical condition or an acute spell of illness. To accommodate these patients, the physician may request that higher limits be approved for a particular Utilization Threshold or an exemption be approved for a particular Utilization Threshold by submitting a "Threshold Override Application" form to the Medicaid Override Application System (MOAS).

In order to help avoid a disruption in an enrollee's medical care, a "nearing limits" letter will be sent to the enrollee, when the authorized services are being used at a rate that will utilize all available services, in less than the current benefit year. This letter will advise the enrollee to contact his/her provider who should submit the Threshold Override Application form to increase the enrollee's service limits. The provider will also be alerted to the fact that this letter has been sent via a message on the MEVS terminal.

When an enrollee reaches his/her Utilization Threshold, a letter will be sent to the enrollee and the provider will be alerted to this fact via a message on the MEVS terminal.

Certain Medicaid enrollees will be exempt from most Utilization Thresholds because they receive their medical care though Managed Care Programs, i.e., Health Maintenance Organizations, prepaid capitation service plans.

There are also some services which are exempt from Utilization Threshold and the enrollee's use of these services is not limited under this Program. Such services include:

- Family Planning,
- Methadone Maintenance Treatment,
- Certain obstetric services,
- Child/Teen Health Program services, and
- Kidney dialysis.

## Recipient Restriction Program

The Recipient Restriction Program (RRP) is an administrative mechanism whereby selected Medicaid enrollees with a demonstrated pattern of abusive utilization of Medicaid services must receive their medical care from a designated primary provider(s). The goals of the RRP are the elimination of abusive utilization behavior and the promotion of quality care for restricted enrollees through coordination of the delivery of select medical services.

The DOH and LDSS may restrict enrollees to the following provider types:

- Physicians,
- Clinics,
- Pharmacies,
- Inpatient hospitals,
- Podiatrists,
- Dentists and
- Durable Medical Equipment providers.

These restrictions may be imposed individually or in conjunction with one another. To promote coordinated medical care, the RRP prohibits restricted enrollees from obtaining

certain ancillary services such as laboratory and transportation ordered by non-primary providers.

Billing information relating to the RRP is located in the **Billing Guidelines** of each specific provider manual.

### MEVS Implications for the RRP

It is important for all providers to properly access the MEVS to ensure that the enrollee is eligible and to:

- Avoid rendering services to a patient who is restricted to another provider; and/or
- Ensure that ordered services are provided at the request of a restricted enrollee's primary provider or a provider to whom the enrollee was referred by his/her primary provider.

For instructions on MEVS transactions, please refer to the MEVS Provider Manual online at:

http://www.emedny.org/ProviderManuals/index.html.

## Managed Care

Managed Care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care. The Managed Care Organization (MCO) is responsible for assuring that enrollees have access to a comprehensive range of preventative, primary and specialty services. The MCO may provide services directly or through a network of providers. The MCO receives a monthly premium for each enrollee to provide these services.

In a MCO, each Medicaid enrollee is linked to a primary care practitioner. This provider may be a private practicing physician, on staff in a community health center or outpatient department, or may be a nurse practitioner. Regardless of the setting, the primary care provider is the focal point of the Managed Care system. This practitioner is responsible for the delivery of primary care, and also coordinates and case manages most other necessary services. Another feature of managed care is 24-hour, 7-day/week access to care.

A Medicaid enrollee enrolled with a MCO remains eligible for the full range of medical services available in the Medicaid Program. However, an enrolled enrollee is required to access most health care services through his/her MCO. When an enrollee is determined Medicaid-eligible, he/she has the opportunity to enroll with a MCO, but not all enrollees will be enrolled in a MCO.

Certain individuals are excluded from participating on Medicaid Managed Care:

- Individuals who “spend down” to obtain Medicaid eligibility;
- Foster care children whom the fiscally responsible LDSS has placed under the auspices of a voluntary child (foster) care agency;
- Medicare/Medicaid dual eligibles;
- Residents of State-operated inpatient psychiatric facilities;
- Residents of residential treatment facilities for children and youth;
- Enrollees of Mental Health Family Care services;
- Residents of residential health care facilities at the time of enrollment;
- Participants in a long term care capitation demonstration project;
- Infants of incarcerated mothers;
- Participants in the Long Term Home Health Care Program;
- Certified blind or disabled children who are living apart from their parents over 30 days;
- Individuals expected to be eligible for Medicaid less than 6 months;
- Individuals receiving hospice services;
- Individuals receiving services from a Certified Home Health Agency when it has been determined that they are not suitable for managed care enrollment;
- Individuals enrolled in the Restricted Enrollee Program with a primary physician, clinic, dental, DME, or inpatient provider;
- Enrollees who have other third party insurance so that managed care enrollment is not cost-effective.

## MEVS Implications for Managed Care

Provider must check the MEVS prior to rendering services to determine the enrollee’s Medicaid eligibility and the conditions of Medicaid coverage. If the Medicaid enrollee is enrolled with a MCO, the first MEVS coverage message will indicate, “Eligible PCP”.

> **Note**: PCP stands for Prepaid Capitation Plan (or MCO). Please refer to the MEVS manual for instructions on Managed Care transactions.

While MCOs are required to provide a uniform benefit package, there may be some variations between MCOs. The MEVS coverage codes are general service categories within the general category. To avoid payment problems, providers should contact the MCO whenever possible before providing services.

Providers may bill Medicaid and receive payment for any services not covered by the MCO. However, Medicaid will deny payment for services which are covered by the MCO. If a provider is not a participating provider in the enrollee's MCO, and the provider is certain that the service is covered by the MCO, then the provider must first refer the enrollee to his/her MCO for that service, or call the MCO prior to providing service.

# Section VI – Definitions

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

## Emergency

An emergency is defined as care for patients with severe, life threatening, or potentially disabling conditions that require immediate intervention.

## Emergency Services

Care provided after a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could reasonably result in:

- serious impairment of bodily functions;
- serious dysfunction of a bodily organ or body part; or
- would otherwise place the enrollee's health in serious jeopardy.

## Factor

A person or an organization such as a collection agency, service bureau or an individual that advances money to a provider for accounts receivable in return for a fee, deduction, or discount based on the dollar amount billed or collected. The accounts receivable are transferred by the provider to the factor by means of assignment, sale or transfer, including transfer through the use of power of attorney.

## Local Professional Director

The Local Professional Director (also known as the Local Medical Director or Reviewing Health Professional) is an individual who, under Section 365-b of the NYS Social Services Law, serves under the general direction of the Commissioner of Social Services and has responsibility for:

- supervising the medical aspects of the Medicaid Program,
- monitoring the professional activities related to the Program, and
- taking all steps required to ensure that such activities are in compliance with Social Services Law and Regulations and Public Health Law and Regulations.

## Managed Care

Managed care is a comprehensive and coordinated system of medical and health care service delivery encompassing ancillary services, as well as acute inpatient care.

## Prior Approval

Prior Approval is the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

**Prior approval does not guarantee payment.**

## Prior Authorization

Prior authorization is the acceptance by the Local Commissioner of Social Services, or his/her designated representative, of conditional financial liability for a service or a series of services to be rendered by the provider.

**Prior authorization does not guarantee payment.**

## Qualified Medicare Enrollee

Qualified Medicare Enrollees (QMBs) are individuals who have applied to Medicaid through the LDSS and have been determined eligible for Medicaid payment, as appropriate, of Medicare premiums, deductibles and coinsurance for Medicare-approved services.

QMB status is determined via the MEVS.

## Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York as set forth in the Official Codes, Rules and Regulations of the Department of Health or any other State or Federal statute or regulation which relates to the quality of care, services and supplies or the fiscal integrity of the Medicaid Program.

## Urgent Medical Care

A situation in which the patient has an acute or active problem which, if left untreated, might result in:

- an increase in the severity of symptoms;
- the development of complications;

- increase in recovery time;
- the development of an emergency situation.

# NEW YORK STATE
# MEDICAID PROGRAM

# INFORMATION FOR ALL PROVIDERS
# GENERAL BILLING

# Table of Contents

# Common Benefit Identification Card

There are four types of Common Benefit Identification Cards (CBIC) or documents with which you will need to become familiar;

- a photo card,
- a non-photo card,
- a paper replacement CBIC and
- a Temporary Medicaid Authorization (DSS-2831A).

The photo and non-photo cards are permanent plastic cards and each contains information needed for verifying eligibility for a single enrollee. Each card contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

Additionally, each card contains an access number, a sequence number, an encoded magnetic strip and a signature panel. The photo ID card also contains a photo. Neither card contains an expiration date.

**The provider must verify enrollee eligibility via the Medicaid Eligibility Verification System (MEVS) each time service is provided to be assured that an enrollee is eligible.**

If an enrollee's permanent plastic ID card has been lost, stolen or damaged, the enrollee will be issued a temporary replacement paper CBIC (DSS-3713), which contains the following information for the enrollee:

- Medicaid identification number;
- first name;
- last name;
- middle initial;
- sex; and
- date of birth.

This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via MEVS whenever a temporary replacement card (DSS-3713) is presented.

In some circumstances, the enrollee may present a Temporary Medicaid Authorization (DSS-2831A). This document is issued by the local department of social services

(LDSS) when the enrollee has an immediate medical need and a permanent plastic identification card has not yet been received by the enrollee. It is a guarantee of eligibility for the authorization period indicated (maximum 15 days); therefore, verification of eligibility via MEVS is not required. Limitations and/or restrictions are listed on the Authorization. In these cases it will be necessary for some providers to place a code of "M" in the "SA EXCP CODE" field on the eMedNY billing form in order to indicate that the enrollee had a Temporary Medicaid Authorization. Please refer to the Billing Guidelines section of your specific provider manual for instructions. Questions regarding eligibility should be directed to the LDSS issuing the DSS-2831A.

**Note: Each of these documents is described in greater detail in the "Common Benefit Identification Card" section of the MEVS Provider Manual.**

The MEVS Provider Manual is available to Medicaid enrolled providers. This manual can be accessed at or downloaded from:

http://www.emedny.org/ProviderManuals/index.html.

Samples of the four types of CBIC are shown and detailed descriptions are provided in the **MEVS Provider Manual** section entitled, "Common Benefit Identification Cards".

**Note:** The sample cards shown in the **MEVS Provider Manual** are issued to New York State Medicaid enrollees whose district of fiscal responsibility is within eMedNY. Claims for patients with non-eMedNY CBIC should be sent to the Local Department of Social Services indicated in the MEVS response.

## Voice Interactive Phone System

Medicaid offers the Voice Interactive Phone System (VIPS) to afford providers the opportunity to conduct a name search to locate the Client Identification Number (CIN) of Medicaid enrollees who were unable to present their cards at the time of service. This system is accessible by calling (518) 472-1550 from a touch-tone telephone and following the voice prompts. There is a charge of $.85 per minute.

# Prior Approval Rosters

Prior approval/authorization rosters contain information necessary to submit claims for certain services provided to Medicaid enrollees. Rosters contain necessary billing information, including, but not limited to: prior approval/authorization number, client identification number, applicable approved/authorized procedure/rate code/s, and date/s of service.

## Electronic Roster

Rosters are available electronically in Portable Document Format (pdf) via the eMedNY eXchange, at no additional expense to providers, and are delivered in advance of hard copy rosters so claims may be submitted and paid earlier. Electronic rosters are not in HIPAA-compliant format, therefore providers need not purchase additional software to read or interpret roster information.

Weekly rosters for transportation and personal care services providers are posted every Monday. For all other provider types, a roster is posted the day after prior approvals are approved.

eXchange works like email. A provider, who has requested an electronic roster, would log on to the eXchange via the eMedNY website. After entering an assigned User Identification Number and password, the provider is able to print the roster and/or detach the roster file to save it on a personal computer for future reference.

**What information is included on the electronic roster?**

- Roster Date
- PA Number
- Procedure/Rate Code
- Approved Quantity
- Approved Times
- Patient Name
- Patient Medicaid ID
- Patient Gender
- Patient Date of Birth
- Patient County
- Billing Provider Name
- Billing Provider ID
- Ordering Provider ID
- Dates of Service
- Approved Amount

**How does a provider obtain a User Identification Number and password for eXchange?**

First, the eMedNY eXchange is available only to providers who have enrolled in ePACES. Once a provider is enrolled in ePACES, then the provider is automatically enrolled in eXchange.

After successful enrollment in ePACES, the provider calls the eMedNY Call Center at (800) 343-9000 to activate their eXchange inbox.

Providers not yet enrolled in ePACES will need the following prior to contacting the Call Center to enroll:

- Computer with internet access;
- Valid email address;
- Internet browser (Explorer v.4.01, Netscape v 4.7 or higher);
- Operating system of Microsoft Windows, Macintosh or Linux; and
- NYS Medicaid Provider Identification number.

The electronic prior approval request for is available at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

# Billing for Medical Assistance Services

Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. Acceptable reasons for a claim to be submitted beyond 90 days are listed below.

If a claim is denied or returned for correction, it must be corrected and resubmitted within **60 days of the date of notification** to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

All claims must be **finally** submitted to the eMedNY Contractor and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

## Claims Submitted for Stop-Loss Payments

All claims for Stop-Loss payment must be finally submitted to the Department, and be payable, within two years from the close of the benefit year in order to be valid and enforceable against the Department.

For example, calendar year 2002 payable claims must be finally submitted no later than December 31, 2004 with corresponding cutoff for future years.

## Claims Over 90-Days Old, Less Than Two Years Old

Paper claims over 90 days of the date of service must be submitted with a 90-day letter attached (with the exception of Third Party Insurance Processing Delay). The reason for the delay should be indicated on a piece of paper the same size (8½ x 11) and paper quality as the invoice.

Because the claim forms do not contain an invoice number, **each** claim must have its **own** 90-day letter attached. This allows the imaging system to simultaneously track each claim and attachment.

## Acceptable Delay Reasons

Claims over 90 days, and less than two years, from the date of service may be submitted if the delay is due to one or more of the following acceptable conditions. *The applicable delay reason(s) must be included on a 90-day letter attached to the claim.*

- **Proof of Eligibility Unknown or Unavailable – Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

The enrollee applied for Medicaid and their eligibility was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within 30 days from the time of notification.

- **Litigation**

  This means there was some kind of litigation involved and there was the possibility that payment for the claim may come from another source, such as a lawsuit.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Authorization Delays/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Certifying Provider/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**

  For example: Provider enrollment may back date the effective date of a Specialty Code.

- **Delay in Supplying Billing Forms**

- **Third Party Processing Delay – Medicare and Other Third Party Processing Delays**

  The claim had to be submitted to Medicare or other Third Party Insurance before being submitted to Medicaid.

  The claim must be submitted within thirty (30) days from the time submission came within the control of the Provider.

- **Delay in Eligibility Determination/Delay in Medicaid Client Eligibility Determination (including Fair Hearing)**

  This means the enrollee applied for Medicaid and their eligibility date was backdated. If the claim ages over 90 days while this process is taking place, then this reason applies.

The claim must be submitted within thirty (30) days from the time of notification.

- **Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules**

  This means the Provider submitted the claim on time and was denied for some other reason. If the date of service is over 90 days when they rebill, this reason applies.

  The claim must be submitted within thirty (30) days from the time of notification.

- **Administration Delay in the Prior Approval Process/Administrative Delay (prior approval) by the Department of Health or other State agency**

  IPRO denial/reversal (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.

- **Other/Interrupted Maternity Care**

  Prenatal care claims over 90 days because delivery was performed by a different practitioner.

## Claims Over Two Years Old

All claims over two years old will be denied for **edit 1292** (*DOS (date of service) Two Yrs (years) Prior to Date Received*). The Department will *only* consider claims over two years old for payment only if the provider can produce documentation verifying that the cause of the delay was the result of one or more of the following:

- Errors by the Department, the local social services district, or another agent of the Department; or

- Court-ordered payments.

If a Provider believes that claims denied for edit 1292 are payable due to one of the reasons above, they may request a review. All claims **must** be submitted **within 90 days of the date on the remittance advice** with supporting documentation to:

**New York State Department of Health**
**Two Year Claim Review**
**150 Broadway, Suite 6E**
**Albany, New York 12204-2736.**

Claims submitted for review without the appropriate documentation, or those not submitted within the 90-day time period for review, will not be considered.

When a provider **voids** a previously paid claim and now wishes to resubmit, the resubmission is treated as a **new claim** and will be subjected to the criteria above for the submission of claim(s) over two years old. All timely submission rules apply. The new claim will not be considered as an agency error and, therefore, **will not** qualify for a waiver of the two-year regulation. Adjustments, rather than voids, should always be billed to correct a paid claim(s).

## Electronic Claims Submission

Most claims for payment of medical care, services and supplies may be submitted electronically, including originals, resubmissions, adjustments and voids. The only exceptions are claims that require paper attachments such as enrollee's "consent forms" or provider's procedure reports for manual pricing.

When a file is submitted to eMedNY, a series of response files are returned to the submitter to communicate the status of the transaction. Errors in transmissions may cause transactions not to be processed. eMedNY sends status files that can prevent surprises and negative impacts on cash flow. Please review the list of frequently asked questions online at:

http://www.emedny.org/hipaa/FAQs/index.html.

If you would like more information about computer generated claims submission or require the input specifications for the submission of the types of claims indicated above, please call the eMedNY Call Center at (800) 343-9000.

## Claim Status Options

Medicaid offers a number of tools to assist providers seeking claim status information without having to wait for remittance statements. eMedNY Call Center staff are **not** able to perform routine claim status checks for providers and submitters waiting for their remittances to be delivered.

### ePACES

To request claim status for ePACES claims, providers just need to select from a list of submitted claims. The status of ePACES claims is usually available on the same day the claim was submitted.

For claims submitted via other methods, ePACES requires the key entry of a few pieces of claim data in order to retrieve the status, including the paid amount. Availability of the claim status for claims submitted via other methods may vary depending on the submission method and the time it reached the eMedNY Contractor for processing.

### ePACES Real Time

The status of claims, including the paid amount, submitted via "Real Time" is available for professional claims immediately following submission.

## Electronic Claim Status Request

Electronic requests can be submitted as batch files. Submitters need a software program to produce the requests in a HIPAA-compliant format and to interpret the 277 Claim Status Response.

## Electronic Claim Status Responses

These are returned via ePACES or the 277 transaction containing the HIPAA-compliant response codes. To assist providers with interpreting the response codes, an edit mapping document is available online at:

http://www.emedny.org/hipaa/Crosswalk/index.html.

## Paper Remittance

Claim status information is available two and one half weeks after processing is completed.

## Electronic Remittance

To receive Electronic Remittances, providers must submit a completed *Electronic Remittance Request Form,* available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

Electronic Remittances generally include the status of electronically and paper submitted claims as well as state-submitted adjustments and voids whenever providers who have only one Electronic Transmitter Identification Number sign up for electronic remittances.

**Note:** State-submitted adjustments and voids are transactions submitted by New York State or one of its contractors and are based upon audit findings.

The *Electronic Remittance Request Form* is available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

## Electronic Funds Transfer

Medicaid funds issued to a provider as a result of paper or electronic claims submission can be electronically transferred to a designated bank account or accounts. Providers do not have to submit claims electronically to take advantage of the convenience of EFT. To enroll in EFT, complete the EFT Provider Enrollment Form, available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html.

After submitting the *Form*, please allow four to six weeks for processing.

## Claims Pended for Review by the Office of the State Comptroller

The New York State Constitution requires the Office of the State Comptroller (OSC) to audit all vouchers before payment, including claims that are submitted to the Medicaid Program. OSC will suspend certain claims from the Medicaid payment procedure in order to conduct a thorough review of those claims.

Some providers will see an edit code and reason associated with the OSC audit:

**02014 – Claim Under Review by the Office of the State Comptroller.**

If a provider is receiving the HIPAA-compliant error codes, then the OSC edit will be mapped to:

**Claim Adjustment Reason Code 95 – Benefits Adjusted. Plan Procedures Not Followed.**

If a provider has claims pending or denied for this reason, a representative from OSC will contact the provider to discuss the provider's claims. This may include scheduling an appointment to visit the provider's facility to inspect medical records and other documentation supporting the claims being reviewed.

Under the Code of Federal Regulations (45 CFR § 164.512(d)(1) (HIPAA)), medical providers are permitted to disclose protected health information to an oversight agency, for oversight activities which are authorized by law, such as audits. For these purposes, OSC is an oversight agency.

## HIPAA Claim Denials

With the implementation of HIPAA-standardized claim error reasons, it can be difficult to pinpoint the specific reason for a claim denial because HIPAA requires that denied claims be assigned a *Claim Adjustment Reason Code*.

An Edit/Error Knowledgebase tool for analyzing claim edit codes and/or claim status codes is available online at:

http://www.emedny.org/hipaa/edit_error/KnowledgeBase.html.

## Good Cause

Medicaid providers should always bill available health insurance unless they received authorization from the DOH that "good cause" exists not to bill the health insurance. Health insurance is only determined to be available if the Medicaid Eligibility Verification System (MEVS) indicates that the insurance covers the particular service for which the provider would be billing Medicaid.

Circumstances in which the DOH must determine "good cause" not to bill health insurance involve situations where the billing could jeopardize the emotional or physical health, safety and/or privacy of the Medicaid enrollee. These circumstances commonly arise but are not restricted to occasions on which reproductive health services such as family planning, pregnancy-related services or treatment of sexually transmitted diseases are provided.

> *When warranted, providers on behalf of their patients may request a "good cause" determination and an authorization for not billing the health insurance.*

If a particular patient wants the service to remain confidential, the provider must contact the DOH **weekdays between 8:00am and 4:45pm** at:

**(800) 541-2831**.

If "good cause" is granted, the provider must document the date of the call and that DOH staff gave permission not to bill the health insurance. The information obtained may be utilized as documentation for future audits or claim reviews.

Once a positive determination of "good cause" has been received, the provider must enter $0.00 in the insurance payment field of the Medicaid claim form. *Since the DOH monitors $0.00 filled claims, it is especially important to obtain the previously described approval and document that approval.*

# Claim Certification Statement

Provider certifies that:

- I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim;
- I have reviewed this form;
- I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations;
- The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medical Assistance Program;
- Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid;
- All statements made hereon are true, accurate and complete to the best of my knowledge;
- No material fact has been omitted from this form;
- I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact;
- Taxes from which the State is exempt are excluded;
- All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall be promptly furnished upon request to the local departments of social services, the DOH, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services;

- There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion;

- I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its eMedNY Contractor or otherwise is hereby authorized to

    - (1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and

    - (2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the DOH as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Provider Manuals and other official bulletins of the Department.

I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid Program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

# NEW YORK STATE
# MEDICAID PROGRAM

# INFORMATION FOR ALL PROVIDERS

# INQUIRY

# Table of Contents

# Computer Sciences Corporation Contact Information

Computer Sciences Corporation (CSC) is the Medicaid Program's eMedNY Contractor. Contact CSC with questions concerning:

- ePACES (electronic claims);
- obtaining claim forms;
- obtaining prior approval forms;
- Medicaid enrollment;
- obtaining transportation prior authorization for New York City enrollees;
- preparing/completing claim forms;
- remittance statements/billing;
- the Medicaid Eligibility Verification System (MEVS).

## Hours of Operation

For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:

**Monday through Friday 7:00am – 6:00pm EST**

For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:

**Monday through Friday 7:00am – 10:00pm EST**

**Weekends and Holidays 8:30am – 5:30pm EST**

## Telephone Directory

If you are a:

- Physician
- Private Duty Nurse
- Clinical Social Worker
- Dentist
- Nurse Practitioner; or
- Ophthalmic Provider

Call **(800) 343-9000**
**Option 1**

Then, depending on your question:

| If your question is concerning: | Choose: |
|---|---|
| ➢ New Enrollment;<br>➢ ePACES Enrollment;<br>➢ TSN/ETIN applications. | **Sub-option 1** |
| ➢ Explanation of eligibility response;<br>➢ UT service authorization;<br>➢ POS Device Support. | **Sub-option 2** |
| ➢ Obtaining NYC Transportation Prior Authorizations | **Sub-option 3** |
| ➢ Claims;<br>➢ Billing;<br>➢ Remittance;<br>➢ Form orders; and<br>➢ Prior approval. | **Sub-option 4** |

If you are a:

- Pharmacy Provider

Call **(800) 343-9000**
**Option 2**

Then, depending on your question:

| If your question is concerning: | Choose: |
|---|---|
| ➢ New Enrollment;<br>➢ ePACES Enrollment;<br>➢ TSN/ETIN applications. | **Sub-option 1** |
| ➢ For all other questions including:<br>▪ explanation of eligibility response,<br>▪ claims,<br>▪ billing,<br>▪ remittance and<br>▪ prior approval questions including DIRAD. | **Sub-option 2** |

If you are a:

- Hospital;
- Clinic;
- Long Term Care Facility;
- Nursing Agency; or
- Child Care Agency;
- Home Health Agency

Call **(800) 343-9000**
**Option 3**

Then, depending on your question:

| If your question is concerning: | Choose: |
|---|---|
| ➢ New Enrollment;<br>➢ ePACES Enrollment;<br>➢ TSN/ETIN applications. | **Sub-option 1** |
| ➢ Explanation of eligibility response;<br>➢ UT service authorization;<br>➢ POS Device Support. | **Sub-option 2** |
| ➢ Obtaining NYC Transportation Prior Authorizations | **Sub-option 3** |
| ➢ Claims;<br>➢ Billing;<br>➢ Remittance;<br>➢ Form orders; and<br>➢ Prior approval questions. | **Sub-option 4** |

If you are a:

- Durable Medical Equipment;
- Hearing Aid; or
- Laboratory;
- Transportation Provider

Call **(800) 343-9000**
**Option 4**

Then, depending on your question:

| If your question is concerning: | Choose: |
|---|---|
| ➢ New Enrollment;<br>➢ ePACES Enrollment;<br>➢ TSN/ETIN applications. | **Sub-option 1** |
| ➢ Explanation of eligibility response;<br>➢ UT service authorization;<br>➢ POS Device Support. | **Sub-option 2** |
| ➢ Claims;<br>➢ Billing;<br>➢ Remittance;<br>➢ Form orders; and<br>➢ Prior approval questions. | **Sub-option 3** |

If your question concerns:

- MOAS; or
- Threshold override application provider support

Call **(800) 343-9000**
**Option 5**

## Training Requests

Requests for individual provider training can be made by calling

**(800) 343-9000**

or email:

emednyproviderrelations@csc.com

Training Seminars are also available and are designed for specific provider types. Registration, locations and dates are available online at:

http://www.emedny.org/HIPAA/Provider_Training/Training.html.

## Mailing Addresses for Medicaid Correspondence

Correspondence should be mailed to the following address, with the applicable P.O. Box from the table:

**Computer Sciences Corporation**
**P.O. Box _____**
**Rensselaer, New York 12144.**

| P.O. Box | Description of Contents | Form Types |
|---|---|---|
| 4600 | Prior Approval and Prior Authorization Requests | • EMEDNY-3614 (Dental)<br>• EMEDNY-3615 (Drugs…Physician)<br>• EMEDNY-2832 (Hearing Aid)<br>• EMEDNY-1260 (Level of Care)<br>• EMEDNY-3897 (Transportation)<br>• EMEDNY-4106 (Group Transportation)<br>• PA Additional Information |
| 4601 | Claims | • EMEDNY-1500 (HCFA)<br>• EMEDNY-0002 (Form A)<br>• EMEDNY-0003 (Pharmacy)<br>• UB-04 (Institutional) |
| 4602 | Threshold Override Applications | • EMEDNY-0001 (TOA) |
| 4603 | Provider Enrollment Applications | • All Fee-For-Service and Rate-Based Enrollment Packets |
| 4604 | Edit Review | • Provider submitted documentation to adjudicate claims |

| P.O. Box | Description of Contents | Form Types |
|---|---|---|
| 4605 | Remittance Retrieval | • Requests from providers for copies of remittance statements |
| 4606 | Additional Information | • Provider Enrollment Additional Information Form with attachments |
| 4610 | Provider Maintenance | • Provider maintenance (update) forms and related correspondence |
| 4614 | Electronic Form Requests | • Electronic Certifications<br>• ETIN Applications<br>• Security Packet A<br>• Security Packet B<br>• Electronic Remittance Request<br>• Electronic Prior Approval Request<br>• Remittance Sort Request<br>• Pended Claim Recycle Request<br>• Request to Disaffiliate/Delete an ETIN |
| 4616 | Electronic Funds Transfer | • Electronic Funds Transfer Enrollment Forms |

# Medicaid Program Contact Information

| For questions concerning: | Contact: |
|---|---|
| **Check Amounts**<br>To obtain check amounts prior to the release of the check, select the "Check Call" option from the menu of services offered. Only the current week's check amount will be reported. | Department of Health<br><br>(866) 307-5549 |
| **Child Health Plus** | (800) 698-4KIDS |
| **Claim Response Status for ePACES Users** | http://www.emedny.org/hipaa/Crosswalk/index.html |
| **Dental/Orthodontia Services**<br>**Dental Pended Claims** | Dental Review Unit<br>(800) 342-3005 Option #2 |
| **Diagnosis Codes** | http://www.cms.hhs.gov/icd9providerdiagnosticcodes/<br><br>The list of diagnosis codes is also available through publishing houses. |
| **Durable Medical Equipment**<br>Prior Approval | Non-DVS/DiRad – Except Buffalo Area Counties<br>(800) 342-3005<br><br>Non-DVS/DiRad – Buffalo Area Counties<br>(Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming)<br>(800) 462-8407<br><br>PA Overrides of DVS/DiRad (Statewide)<br>(800) 342-3005 |
| **Elderly Pharmaceutical Insurance Coverage Program (EPIC)** | (800) 634-1340 |
| **Electronic Funds Transfer Provider Enrollment Form**<br><br>**Electronic Prior Approval Request Form**<br><br>**Electronic Transmitter Identifier Number (ETIN)** | http://www.emedny.org/info/ProviderEnrollment/index.html |

| For questions concerning: | Contact: |
|---|---|
| **Electronic Transactions Vendors** | http://www.emedny.org/hipaa/vendors/index.html |
| **eMedNY** | http://www.emedny.org |
| **eMedNY Companion Guides**<br>**Sample Files** | http://www.emedny.org/HIPAA/index.html |
| **Enrollee Eligibility Determination**<br><br>Eligibility discrepancies must be reported to the enrollee's local social services district. CSC's MEVS staff cannot address these calls nor resolve eligibility issues.<br><br>When the provider believes the individual is covered by Medicaid, but does not have the client identification number, assistance can be obtained by calling this number and selecting "Name Search" from the menu of services offered. There is a charge of $0.85 per minute for this optional service. A touch-tone telephone is required. | Department of Health<br><br>(866) 307-5549<br><br>(518) 472-1550 |
| **Family Health Plus** | (877) 9FHPLUS |
| **Managed Care** | (518) 486-9015<br>(800) 206-8125<br><br>omcmail@health.state.ny.us |
| **Medicaid Inspector General**<br>Fraud Referrals | www.omig.state.ny.us<br><br>http://www.nysomig.org/data/component/option,com_fileforms/Itemid,47/<br><br>**(877) 87FRAUD** |
| **Medical Pended Claims**<br>**Two-Year Old Claims** | In State<br>(800) 342-3005 Option #3<br><br>Out of State<br>(518) 474-3575 |

| For questions concerning: | Contact: |
|---|---|
| **Medicaid Policy**<br><br>Call Center Help Line/Co-Pay Hotline<br>Fraud/Forgery Hotline<br>Medical/Dental Prior Approval<br>Restricted Recipients/Utilization Threshold<br>Two-year billing regulations | medicaid@health.state.ny.us<br><br>(800) 541-2831<br>(877) 891-7283<br>(800) 342-3005<br>(518) 474-6866<br>(800) 562-0856 menu #4 |
| **Medical Prior Approval**<br>➢ Nursing<br>➢ Out-of-State Inpatient Hospital Services<br>➢ Audiology | (800) 342-3005 Option #1 |
| ***Medicaid Update***<br>• Missing issues<br>• Request to receive electronic version | http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm<br><br>Email:<br>medicaidupdate@health.state.ny.us<br><br>(518) 474-5187 |
| **New York State Department of Health** | www.nyhealth.gov |
| **Newborn Screening Program** | (518) 473-7552 |
| **Personal Care Services**<br>Prior Authorization | Local Department of Social Services |
| **Pharmacy Policy and Operations** | (518) 486-3209<br><br>ppno@health.state.ny.us |
| **Private Duty Nursing Services** | Broome (607) 778-2707<br>Chemung (607) 737-5487<br>Erie (716) 858-2375<br>Oneida (315) 798-5456<br>Schenectady (518) 386-2253<br>Tompkins (607) 274-5278<br>Westchester (914) 813-5440<br>All others not listed (800) 342-3005 |
| **Restricted Recipient Program** | **NYC**<br>(212) 630-1081<br>(212) 630-1087<br>(212) 630-1089<br><br>**Outside NYC**<br>(518) 474-6866 |

| For questions concerning: | Contact: |
|---|---|
| **Sterilization & Hysterectomy Consent Forms**<br><br>➢ DSS-3113 Hysterectomy Receipt of Information<br><br>➢ DSS-3113S Hysterectomy Receipt of Information (Spanish)<br><br>➢ DSS-3134 Sterilization Consent<br><br>➢ DSS-3134S Sterilization Consent (Spanish) | http://www.health.state.ny.us/health_care/medicaid/publications/ldssforms |
| **Transportation** | (518) 474-5187 or (518) 473-2160<br><br>MedTrans@health.state.ny.us<br><br>**Outside NYC**<br>Local Department of Social Services<br><br>**Obtain NYC Prior Authorization**<br>(800) 343-9000 |

# Fee-for-Service Provider Enrollment File Forms

Fee-for-Service Providers:

- Chiropractor
- Clinical Social Worker
- Midwife
- Nursing Services (LPN/RN)
- Podiatrist
- Rehabilitation Services
- Durable Medical Equipment
- Laboratory
- Service Bureau
- Clinical Psychologist
- Dental/Mobile Van
- Nurse Practitioner
- Physician/Group
- Portable X-Ray Supplier
- Vision Care
- Hearing Aid
- Pharmacy
- Transportation

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|---|---|
| Enrollment Forms<br>Maintenance Forms | http://www.emedny.org/info/ProviderEnrollment/index.html |

# Rate Based Provider Enrollment File Forms

Rate Based Providers:

- Adult Day Care Program
- Assisted Living Program
- Case Management
- Child Care Agency
- Clinic
- Community Residence
- Diagnostic & Treatment Center
- Emergency Room
- HCBS/TBI Waiver Provider
- Home Health Agency
- Hospice
- HMO
- Hospital
- Nursing Service (Registry)
- Long Term Home Health Care Prog.
- Personal Emergency Response System Provider
- Personal Care Provider
- Residential Health Care Facility (Nursing Home)
- Prepaid Capitation Group
- School Supportive Health Service
- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

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| Provider Change of Address | http://www.emedny.org/info/ProviderEnrollment/index.html |
| Disclosure of Ownership Form<br><br>For use when ownership interest changes occur. | To receive the form:<br><br>Call (800) 342-3005 Option # 4<br><br>or write to:<br><br>RBU@health.state.ny.us<br>***Subject Line Must State: "Request Disclosure Form" and contain the name and Medicaid provider identification number of the entity.***<br><br>***Completed*** forms should be mailed to:<br><br>New York State Department of Health<br>Office of Health Insurance Programs<br>Division of Program Operations & Systems<br>Rate Based Provider Unit<br>150 Broadway<br>Albany, New York 12204-2736 |

# Pharmacy Programs

To obtain prior authorization for drugs subject to the Mandatory Generic Drug Program, the Preferred Drug Program, or the Clinical Drug Review Program, or for prior authorization of non-preferred drugs, call:

**(877) 309-9493**
***and follow the appropriate prompts:***

| | |
|---|---|
| • To validate a prior authorization **ending with "W"** | Press 1 |
| • To validate a prior authorization that **does not end with "W"** | Press 2 |
| • For information or technical assistance with a prior authorization | Press 3 |
| • For a prior authorization program overview<br>• Recent changes to the Preferred Drug Program | Option 9 |

**Requests for prior authorization of non-preferred drugs may also be faxed to:**

**(800) 268-2990**
***Faxed requests may take up to 24 hours to process.***

| For questions concerning: | Contact: |
|---|---|
| Prior authorization worksheet/fax form | https://newyork.fhsc.com/providers/PDP_forms.asp |
| Current Preferred Drug List<br>Preferred Drug Quick List | https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf |
| Request email notification of changes to Preferred Drug List | NYPDPNotices@firsthealth.com |
| To obtain a supply of Preferred Drug Program educational materials for Medicaid enrollees | (518) 951-2040 |
| Clinical concerns<br>Preferred Drug Program questions | (877) 309-9493 |
| Billing | (800) 343-9000 |

# Local Departments of Social Services

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|---|---|
| Albany County<br>Department of Social Services<br>162 Washington Avenue<br>Albany, New York 12210<br>*(518) 447-7300*<br>http://www.albanycounty.com/departments/dss/ | Allegany County<br>Department of Social Services<br>7 Court Street<br>Belmont, New York 14813<br>*(585) 268-9622*<br>http://www.alleganyco.com/default.asp?show=btn_dss |
| Broome County<br>Department of Social Services<br>36-42 Main Street<br>Binghamton, New York 13905-3199<br>*(607) 778-8850*<br>http://www.gobroomecounty.com/dss/ | Cattaraugus County<br>Department of Social Services<br>One Leo Moss Drive, Suite 6010<br>Olean, New York 14760<br>*(716) 373-8070*<br>http://www.co.cattaraugus.ny.us/dss/ |
| Cayuga County<br>Department of Social Services<br>County Office Building<br>160 Genesee Street<br>Auburn, New York 13021-3433<br>http://cayugacounty.us/hhs/index.html | Chautauqua County<br>Department of Social Services<br>H.R. Clothier Building<br>Mayville, New York 14757<br>*(716) 753-4421*<br>http://www.co.chautauqua.ny.us/hservframe.htm |
| Chemung County<br>Department of Social Services<br>Human Resources Center<br>P.O. Box 588<br>425 Pennsylvania Avenue<br>Elmira, New York 14902-1795<br>*(607) 737-5309* | Chenango County<br>Department of Social Services<br>County Office Building<br>P.O. Box 590, 5 Court Street<br>Norwich, New York 13815<br>*(607) 337-1500* |
| Clinton County<br>Department of Social Services<br>13 Durkee Street<br>Plattsburgh, New York 12901<br>*(518) 565-3300*<br>http://www.clintoncountygov.com/Departments/DSS/index.htm | Columbia County<br>Department of Social Services<br>P.O. Box 458<br>25 Railroad Avenue<br>Hudson, New York 12534-2514<br>*(518) 828-9411* |

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|---|---|
| Cortland County<br>Department of Social Services<br>County Office Building<br>60 Central Avenue<br>Cortland, New York 13045-5590<br>*(607) 753-5248*<br>http://www.cortland-co.org/dss/ | Delaware County<br>Department of Social Services<br>111 Main Street<br>Delhi, New York 12601-3302<br>*(607) 746-2325* |
| Dutchess County<br>Department of Social Services<br>60 Market Street<br>Poughkeepsie, New York 12601-3302<br>*(845) 486-3000*<br>http://www.co.dutchess.ny.us/CountyGov/Departments/SocialServices/SSIndex.htm | Erie County<br>Department of Social Services<br>95 Franklin Street<br>Buffalo, New York 14202-3935<br>*(716) 858-8000*<br>http://www.erie.gov/depts/socialservices/ |
| Essex County<br>Department of Social Services<br>7551 Court Street, P.O. Box 217<br>Elizabethtown, New York 12932-0217<br>*(518) 873-3302* | Franklin County<br>Department of Social Services<br>Court House<br>335 West Main Street, Suite 331<br>Malone, New York 12953<br>*(518) 483-6770*<br>http://franklincony.org/content/ |
| Fulton County<br>Department of Social Services<br>P.O. Box 549<br>4 Daisy Lane<br>Johnstown, New York 12095<br>*(518) 736-5640* | Genesee County<br>Department of Social Services<br>5130 East Main Street, Suite 3<br>Batavia, New York 14020-9407<br>*(585) 344-2580*<br>http://www.co.genesee.ny.us/dpt/socialservices/index.html |
| Greene County<br>Department of Social Services<br>411 Main Street<br>P.O. Box 528<br>Catskill, New York 12414-1716<br>*(518) 943-3200*<br>http://www.greenegovernment.com/department/socialserv/ | Hamilton County<br>Department of Social Services<br>P.O. Box 725- White Birch Lane<br>Indian Lake, New York 12842-0725<br>*(518) 648-6131* |

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|---|---|
| Herkimer County<br>Department of Social Services<br>301 North Washington Street, Suite 2110<br>Herkimer, New York 13350<br>*(315) 867-1291*<br>http://herkimercounty.org/content/Departments/View/10 | Jefferson County<br>Department of Social Services<br>Human Services Building<br>250 Arsenal Street<br>Watertown, New York 13601<br>*(315) 782-9030* |
| Lewis County<br>Department of Social Services<br>P.O. Box 193<br>Lowville, New York 13367<br>*(315) 376-5400*<br>http://lewiscountyny.org/content/Departments/View/30? | Livingston County<br>Department of Social Services<br>3 Murray Hill Drive<br>Mount Morris, New York 14510<br>*(585) 243-7300*<br>http://www.co.livingston.state.ny.us/dss.htm |
| Madison County<br>Department of Social Services<br>Madison County Complex<br>P.O. Box 637<br>Wampsville, New York 13163<br>*(315) 366-2211*<br>http://www.madisoncounty.org | Monroe County<br>Department of Social Services<br>111 Westfall Road, Room 660<br>Rochester, New York 14620-4686<br>*(585) 274-6000*<br>http://www.monroecounty.gov/hs-index.php |
| Montgomery County<br>Department of Social Services<br>County Office Building<br>P.O. Box 745<br>Fonda, New York 12068<br>*(518) 853-4646* | Nassau County<br>Department of Social Services<br>101 County Seat Drive<br>Mineola, New York 11501<br>*(516) 571-4444*<br>http://www.nassaucountyny.gov/agencies/dss/DSSHome.htm |
| New York City<br>Human Resources Administration<br>180 Water Street<br>New York, New York 10038<br>*(877) 472-8411 within the 5 boroughs*<br>*(718) 557-1399 outside of NYC*<br>http://www.nyc.gov/html/hra/html/home/home.shtml | Niagara County<br>Department of Social Services<br>P.O. Box 506, 20 East Avenue<br>Lockport, New York 14095-3394<br>*(716) 439-7602* |

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|---|---|
| Oneida County<br>Department of Social Services<br>County Office Building<br>800 Park Avenue<br>Utica, New York 13501-2981<br>*(315) 798-5733*<br>http://www.ocgov.net/oneidacty/gov/dept/socialservices/dssindex.html | Onondaga County<br>Department of Social Services<br>Onondaga County Civic Center<br>421 Montgomery Street<br>Syracuse, New York 13202-2933<br>*(315) 435-2985 or (315) 425-2986*<br>http://www.ongov.net/DSS/ |
| Ontario County<br>Department of Social Services<br>3010 County Complex Drive<br>Canandaigua, New York 14424<br>*(585) 396-4060*<br>http://www.co.ontario.ny.us/social_services/ | Orange County<br>Department of Social Services<br>Quarry Road, Box Z<br>Goshen, New York 10924-0678<br>*(845) 291-4000*<br>http://www.co.orange.ny.us/orgMain.asp?orgid=55&storyTypeID=&sid=& |
| Orleans County<br>Department of Social Services<br>14016 Route 31 West<br>Albion, New York 14411-9365<br>*(585) 589-7004*<br>http://orleansny.com/SocialServices/dss.htm | Oswego County<br>Department of Social Services<br>100 Spring Street, P.O. Box 1320<br>Mexico, New York 13114<br>*(315) 963-5000*<br>http://www.co.oswego.ny.us/dss/ |
| Otsego County<br>Department of Social Services<br>197 Main Street<br>Cooperstown, New York 13326-1196<br>*(607) 547-7594*<br>http://www.otsegocounty.com/depts/dss/ | Putnam County<br>Department of Social Services<br>110 Old Route Six<br>Building #2<br>Carmel, New York 10512-2110<br>*(845) 225-7040*<br>http://www.putnamcountyny.com/socialservices/ |
| Rensselaer County<br>Department of Social Services<br>133 Bloomingrove Drive<br>Troy, New York 12180-8403<br>*(518) 283-2000*<br>http://www.rensco.com/departments_socialservices.asp | Rockland County<br>Department of Social Services<br>Building L<br>Sanatorium Road<br>Pomona, New York 10970<br>*(845) 364-2000*<br>http://www.co.rockland.ny.us/Social/ |
| St. Lawrence County<br>Department of Social Services<br>6 Judson Street<br>Canton, New York 13617-1197<br>*(315) 379-2111*<br>http://www.co.st-lawrence.ny.us/Social_Services/SLCSS.htm | Saratoga County<br>Department of Social Services<br>152 West High Street<br>Ballston Spa, New York 12020<br>*(518) 884-4140*<br>http://www.co.saratoga.ny.us/dindex.html |

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|---|---|
| Schenectady County<br>Department of Social Services<br>487 Nott Street<br>Schenectady, New York 12308-1812<br>*(518) 388-4470*<br>http://www.schenectadycounty.com/default.aspx?m=2 | Schoharie County<br>Department of Social Services<br>County Office Building<br>P.O. Box 687<br>Schoharie, New York 12157<br>*(518) 295-8334*<br>http://www.schohariecounty-ny.gov/CountyWebSite/index.jsp |
| Schuyler County<br>Department of Social Services<br>County Office Building<br>105 Ninth Street - Unit 3<br>Watkins Glen, New York 14891<br>*(607) 535-8303*<br>http://www.schuylercounty.us/dss.htm | Seneca County<br>Department of Social Services<br>1 DiPronio Drive<br>Waterloo, New York 13165-0690<br>*(315) 539-1800*<br>http://www.co.seneca.ny.us/dpt-divhumserv-children-family.php |
| Steuben County<br>Department of Social Services<br>3 East Pulteney Square<br>Bath, New York 14810<br>*(607) 776-7611*<br>http://www.steubencony.org/dss.html | Suffolk County<br>Department of Social Services<br>3085 Veterans Memorial Highway<br>Ronkonkoma, New York 11779<br>*(631) 854-9700*<br>http://www.co.suffolk.ny.us/webtemp3.cfm?dept=17&ID=617 |
| Sullivan County<br>Department of Social Services<br>Box 231, 16 Community Lane<br>Liberty, New York 12754<br>*(845) 292-0100* | Tioga County<br>Department of Social Services<br>Box 240<br>Owego, New York 13827<br>*(607) 687-8300*<br>http://www.tiogacountyny.com/departments/health/social_services/ |
| Tompkins County<br>Department of Social Services<br>320 West State Street<br>Ithaca, New York 14850<br>*(607) 274-5336*<br>http://www.tompkins-co.org/departments/detail.aspx?DeptID=41 | Ulster County<br>Department of Social Services<br>1061 Development Court<br>Kingston, New York 12401<br>*(845) 334-5000*<br>http://www.co.ulster.ny.us/resources/socservices.html |

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|---|---|
| Warren County<br>Department of Social Services<br>Municipal Annex<br>1340 State Route 9<br>Lake George, New York 12845<br>*(518) 761-6300*<br>http://www.co.warren.ny.us/depts.php#SOCIALSERVICES | Washington County<br>Department of Social Services<br>Municipal Center<br>383 Broadway<br>Fort Edward, New York 12828<br>*(518) 746-2300*<br>http://www.co.washington.ny.us/Departments/Dss/dss.htm |
| Wayne County<br>Department of Social Services<br>77 Water Street<br>P.O. Box 10<br>Lyons, New York 14489-0010<br>*(315) 946-4881*<br>http://www.co.wayne.ny.us/departments/dss/dss.htm | Westchester County<br>Department of Social Services<br>County Office Building #2<br>112 East Post Road<br>White Plains, New York 10601-5272<br>*(914) 995-5000*<br>http://www.westchestergov.com/health.htm |
| Wyoming County<br>Department of Social Services<br>466 North Main Street<br>Warsaw, New York 14569-1080<br>*(585) 786-8900*<br>http://www.wyomingco.net/socialservices/main.htm | Yates County<br>Department of Social Services<br>County Office Building<br>417 Liberty Street<br>Penn Yan, New York 14527-1118<br>*(315) 536-5183*<br>http://www.yatescounty.org/upload/12/dss/frameset.html |

# NEW YORK STATE
# MEDICAID PROGRAM

## INFORMATION FOR ALL PROVIDERS

## THIRD PARTY INFORMATION

# Table of Contents

# Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which an enrollee has insurance coverage. Such coverage must be utilized for payment of medical services prior to submitting claims to the Medicaid Program.

Under the Medicaid Eligibility Verification System (MEVS), information specific to TPR will be reported to you when you request eligibility verification of a Medicaid enrollee.

> The MEVS response via the Verifone terminal or alternate access will be a two-digit insurance code.
>
> For **Medicaid Prepaid Capitation Plans** only, the two-digit plan code *and* up to 20 alphabetic coverage codes, or the word "ALL" indicating what services are covered, is displayed. The telephone response will be insurance and coverage codes and a two-digit insurance code and up to 20 messages, or "ALL", indicating which services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found at:

http://www.emedny.org/ProviderManuals/index.html.

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid enrollee is covered by more than two carriers, you will receive a response of "ZZ" as an insurance code. "ZZ" indicates additional insurance.

To obtain coverage information when there are more than two carriers, call Computer Sciences Corporation at:

**(800) 343-9000.**

# Insurance Coverage Codes

The following codes are used in MEVS responses to designate the scope of benefits provided by an insurance company.

| Code | Description | Explanation |
|---|---|---|
| A | Inpatient Hospital | All inpatient services are covered except psychiatric care. |
| B | Physician In-Office | Services provided in the physician's office are generally covered. |
| C | Emergency Room | Self-Explanatory. |
| D | Clinic | Both hospital-based and free-standing clinic services are covered. |
| E | Psychiatric Inpatient | Self-Explanatory. |
| F | Psychiatric Outpatient | Self-Explanatory. |
| G | Physician In-Hospital | Physician services provided in a hospital or nursing home are covered. |
| H | Drugs No Card | Drug coverage is available but a drug card is not needed. |
| I | Lab/X-ray | Laboratory and X-ray services are covered. |
| J | Dental | Self-Explanatory. |
| K | Drugs Co-pay | Although insurance carrier expects a co-payment, you may *not* request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment. |
| L | Nursing Home | Some nursing home coverage is available. You must bill until benefits are exhausted. |
| M | Drugs Major Medical | Drug coverage is provided as part of a major medical policy. |

| Code | Description | Explanation |
|---|---|---|
| N | All Physician Services | Physician services, without regard to where they were provided, are covered. |
| O | Drugs | Self-Explanatory. |
| P | Home Health | Some home health benefits are provided. Continue to bill until benefits are exhausted. |
| Q | Psychiatric Services | All psychiatric services, inpatient and outpatient, are covered. |
| R | ER and Clinic | Self-Explanatory. |
| S | Major Medical | The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment. |
| T | Transportation | Medically necessary transportation is covered. |
| U | Coverage to Complement Medicare | All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier *prior* to billing Medicaid. |
| V | Substance Abuse Services | All substance abuse services, regardless of where they are provided, are covered. |
| W | Substance Abuse Outpatient | Self-Explanatory. |
| X | Substance Abuse Inpatient | Self-Explanatory. |
| Y | Durable Medical Equipment | Self-Explanatory. |
| Z | Optical | Self-Explanatory. |
| All | All of the above | All services are covered. |

# Recipient Other Insurance Codes

These codes indicate other insurance carriers under which the enrollee may be covered.

| Ins Cd | Description |
|---|---|
| 02 | HIP Outpatient |
| 05 | Other Insurance Inpt/Outpt |
| 06 | Group Health Inc (GHI) |
| 09 | Union Inpt/Outpt |
| 10 | HIP/HMO |
| 12 | BC/BS Empire |
| 14 | A&P Health And Welfare |
| 18 | Administrative Services Co |
| 20 | Aftra Health And Retirement |
| 22 | AIG |
| 23 | Empire BC |
| 25 | Airfreight Warehouse Corp |
| 27 | Albany International |
| 28 | Allied International Union |
| 29 | Allied Security Health & Welfare |
| 30 | Amalgamated Services |
| 31 | Amerco |
| 32 | American Medical Life Ins |
| 34 | America's Choice Health Plan |
| 35 | Amerihealth Administrators |
| 36 | Atlantis Health |
| 38 | BACL5NY Welfare Fund |
| 39 | Bakers Local 3 |
| 40 | Bakery Drivers Local 802 |
| 41 | BC/BS Carefirst |
| 42 | BC/BS Healthflex Now |
| 43 | BC/BS of Alabama |
| 44 | BC/BS of Greater NY |
| 45 | Empire BS |
| 47 | BC/BS of Iowa-Wellmark |
| 48 | BC/BS of Minnesota |
| 49 | BC/BS of North Dakota |
| 50 | BC/BS of Rhode Island |
| 51 | BC/BS through SSA |
| 52 | Benefit Concepts |
| 53 | Benesight PCHS |
| 54 | Better Health Advantage |
| 55 | BC/BS PP |
| 56 | BC of NY |
| 58 | Capitol Administrators |
| 59 | Carpenters Healthcare Plan |
| 60 | CBSA |
| 61 | Central States |
| 62 | CENTRUS |
| 65 | Chatwins Healthcare Administrators |

| Ins Cd | Description |
|---|---|
| 66 | Christian Brothers Employees |
| 67 | Citywide Central Ins Program |
| 69 | Coalition for Care |
| 70 | Cole Managed Vision |
| 71 | Combined Welfare Fund |
| 72 | Coresource Inc. |
| 74 | Custom Coverage |
| 88 | Elderplan |
| 90 | Davis Vision |
| 99 | New HIP |
| | |
| A1 | Union Am Postal Workers |
| A2 | American Psych Systems |
| A3 | American Medical Life Ins Co |
| A4 | Anthem Life |
| A5 | Aetna Medicare Cost |
| A6 | American National |
| A7 | American Pioneer Life Ins Co |
| A8 | Alta Health Strategies |
| A9 | Wells Fargo |
| AA | Accident Insurance |
| AC | Aetna Life Insurance Co |
| AD | Aetna Variable Annuity Life Ins |
| AE | Countryway Insurance Company |
| AF | American Family Life Insurance |
| AG | Allstate Life Insurance Co |
| AH | Amalgamated Life Ins Co Inc |
| AI | Allstate Insurance CO |
| AJ | Absent Parent Responsibility |
| AK | Allied Benefit Administrators |
| AL | American Group Administrators |
| AM | Americorps |
| AO | Alta Rx Prescription Drugs |
| AP | AARP |
| AQ | American Integrity Ins Co |
| AS | Assoc Plan Admin Inc (APA) |
| AU | American Medical Ins Co |
| AY | Virginia Surety Company Inc |
| AZ | American Progressive Health Ins Co |
| | |
| B1 | BC/BS Highmark |
| B2 | BS of Florida |
| B3 | BS of Massachusetts |
| B4 | BC/BS of Tennessee |
| B5 | BC/BS of Northeast Ohio |

| Ins Cd | Description |
|---|---|
| B6 | BC/BS of New Jersey |
| B7 | Blue Choice Preferred |
| B8 | BC Utica |
| B9 | BS Utica |
| BA | Banker's Life Company |
| BB | Banker's Multiple Life Ins Co |
| BB1 | Regence BC/BS of Oregon |
| BCN | BC/BS of Nebraska |
| BC | BC Central NY |
| BE | BS Western NY |
| BF | Benefit Trust Life Ins Co |
| BG | BS Central NY |
| BH | BS Northeastern NY |
| BI | BS Western NY |
| BJ | BC Rochester |
| BK | BS Rochester |
| BL | BC New Jersey |
| BM | BS New Jersey |
| BN | BC/BS of Central NY–Excellus BC/BS |
| BO | BC/BS of Northeastern NY |
| BP | BC/BS of Western NY |
| BQ | BC/BS of Connecticut |
| BR | BC/BS of Florida |
| BS | Dental Pay |
| BT | BC/BS Massachusetts |
| BV | BC/BS of Vermont |
| BW | BC Florida |
| BY | BC of Massachusetts |
| BZ | BC of Northeastern PA |
| | |
| C1 | BC Capital (Pennsylvania) |
| C3 | Capital District Physicians Health Plan |
| C4 | CIGNA |
| C5 | Community Blue (Buffalo) |
| C6 | Choicecare |
| C8 | Confederation Life Ins |
| C9 | Claim Management Services |
| CA | Tricare Region 1 Claims/CHAMPUS |
| CB | Colonial Penn Franklin Ins Co |
| CBS | Corporate Benefit Services of America |
| CC | Continental Assurance Co |
| CD | Continental Casualty Co |
| CE | BC/BS Michigan |
| CF | BC/BS California |
| CH | Chubb Life America |
| CJ | Columbian Mutual Life Ins Co |
| CK | Combined Life Ins Co of NY |
| CL | Serv Employees Welfare Fund Union |
| CM | Comm Travelers Mutual Ins Co |
| CN | Catskill School Emp Ben Fund Union |
| CO | Companion Life Ins Co |
| CR | Consolidated Mutual Ins Co |

| Ins Cd | Description |
|---|---|
| CS | Continental American Life Ins Co |
| CT | Continental Ins Co |
| CU | CSEA Union |
| CY | BC/BS Greater NY HMO |
| | |
| D1 | BC/BS of the National Capitol Area |
| D2 | ERISCO |
| D3 | Pro Ins Agentents Grp |
| D4 | Oxford Ins Co |
| D5 | DC 37 Health & Security Plan |
| D6 | Benefit Management of Maine |
| D7 | BS of NE Pennsylvania |
| D8 | Chesterfield Resources Inc |
| D9 | Local 32 Health & Pension Fund Union |
| DA | Benefit Administrators Ins |
| DB | BC California |
| DC | Benefit Management Services |
| DE | BC/BS Delaware |
| DF | BC/BS Illinois |
| DG | Diversified Group Brokerage Corp |
| DH | Comprehensive Benefits Co |
| DI | Celtic Life Ins Co |
| DJ | BC/BS Missouri |
| DK | BC of Philadelphia |
| DL | Oxford Health Plan Mcare Risk |
| DP | Diversified Pharmaceutical Svc |
| DR | HIP Greater NY – Medicare Cost |
| DS | HIP Greater NY – Medicare Risk |
| DV | Caremark |
| DW | Blue Preferred HMO (Utica) |
| DX | Delta Dental |
| | |
| E1 | Equicor |
| E2 | Employee Security Fund |
| E3 | Elm-Co Agency Inc |
| E5 | Express Scripts |
| E7 | BC/BS HMSA |
| EA | Empire State Mutual Life Ins Co |
| EB | Equitable Life Assurance Co |
| EC | Emp Mutual Liability Ins Co of Wis |
| ED | Equitable Life Ins Co of Iowa |
| EF | Executive Life Ins Co of NY |
| EJ | Self Insured |
| EM | Empire Plan/State Employees |
| ES | Empire St Carpenters Wlfr Bnft Fnd |
| | |
| F1 | First Fortis (Medical) |
| F2 | First Health |
| F3 | Corporate Health Administrators |
| F5 | Pan American Life |
| F6 | SNL Administrators |
| F7 | United Health Care |

| Ins Cd | Description |
|---|---|
| F8 | Vytra Health Care |
| F9 | First Cardinal |
| FB | Farmer's/Traders Live Ins Co |
| FE | Fidelity and Casualty Co of NY |
| FF | Fidelity Mutual Life Ins Co |
| FG | Diversified Group Administrators |
| FH | Fireman's Ins Co of Newark NJ |
| FI | Fireman's Fund American Life Ins |
| FJ | Eastern Benefit Systems Inc |
| FK | Excellus Rx |
| FL | Pharma Care |
| FM | ECPA |
| FN | Educator's Mutual |
| FQ | EOCNC/Multiplan |
| FR | Foundation Health Plan |
| FU | United American Life Ins Co |
| | |
| G1 | Group Administrators |
| G2 | Guardian Choice |
| G4 | BC/BS Georgia |
| GA | Guardian Ins & Annuity Co Inc |
| GC | Gerber Life Ins Co |
| GE | Government Employees Health Assoc. |
| GF | EPOCH Group |
| GG | Govt Emp Life Ins Co NY (Union) |
| GI | Assure Care |
| GJ | Guardian Life Ins Co of America |
| GK | Genesee Valley Grp Hlth Plan (Roch) |
| GL | Eye med Vision Plan |
| GO | FCE Benefit Administrator |
| GW | Great West Life |
| GX | Longview Fibre Self Insured |
| GZ | Medical Claims Service |
| | |
| H1 | Hollow Metal Trust Fund |
| H4 | First Rehabilitation Life |
| H8 | Gallagher Bassett Service |
| HA | HIP – Health Ins Plan of Greater NY |
| HB | BCS Insurance Company |
| HC | Health and Welfare Life Ins Assoc |
| HD | BC of Utica – Hospital Serv Corp |
| HE | Hartford Acc/Indem Co |
| HF | Hartford Life Ins Co |
| HG | Magna Care |
| HH | National Medical Health Card Systems |
| HI | Home Life Ins Co |
| HJ | Health Plan Administrators |
| HL | Health Care Plan (Buffalo) – Univera |
| HM | HIP of NJ |
| HN | Health Services Medical Corp |
| HO | BC/BS of Utica – Excellus BC/BS |
| HP | BC of Utica–Hsp Srv Pln Lehigh Valley |

| Ins Cd | Description |
|---|---|
| HQ | Health Economics Group |
| HS | Healthways Inc |
| HU | Healthnet |
| HV | Health Claim Services |
| HZ | Horizon Healthcare |
| | |
| IA | Int Life Investors Ins Co |
| IB | Genworth Financial |
| ID | INDECS |
| IF | Independent Health Assoc Inc |
| IG | General American Life |
| IH | Income Protection Policy-Inpt Assign |
| IJ | HMO CNY |
| IK | BC Independence (PA) |
| IT | ITT Life Ins Corp |
| | |
| J1 | JJ Newman and Co |
| J2 | Justo Inc |
| J3 | Advantage Health Plan |
| J4 | North Americare |
| J5 | Phoenix Group Services |
| J8 | Jardine Group Services |
| JA | JC Penney Ins Co |
| JB | John Deere Ins Co |
| JP | General Vision |
| JU | GPA |
| JX | Group Ins Service Center |
| | |
| K1 | Value Behavioral Health |
| KC | BC/BS Kentucky |
| KM | BC/BS WNY Sr. Blue |
| KN | ASO Health Plans |
| KO | Integ Alternatives Comm Network |
| | |
| L2 | Louisiana Office of Grp Benefits |
| LA | Liberty Mutual Life Ins Co |
| LB | Liberty Life Assurance Co |
| LC | Lincoln National Life Ins Co/NY |
| LD | APA Partners |
| LG | Lumbermans Mutual Ins Co |
| LH | Teamsters Local 182 – Union |
| LI | Life of America Ins Co |
| LO | Local 1199 – Union |
| LW | Harvard Pilgrim |
| | |
| M1 | The Maxon Co |
| M3 | McCrew Care |
| M4 | BC/BS Montana |
| MB | Mutual of Omaha Ins Co |
| MC | Unicare |
| MD | Medi-Plan |
| ME | Mail Handlers Benefit Plan |

| Ins Cd | Description |
|---|---|
| MF | Medical Administrators |
| MG | Metropolitan Ins and Annuity |
| MH | Upstate Administration Svc |
| MI | United Food Workers – Union |
| MJ | Monarch Life Ins Co |
| ML | Montgomery Ward |
| MM | Mutual Benefit Life Ins Co |
| MN | Mutual Life Ins Co NY |
| MP | Mutual Protective/Medico Life Ins Co |
| MQ | Mohawk Valley Physicians Hlth Plan |
| MS | Milk Plant Emp Welfare Trust – Union |
| MT | Mid-Hudson Health Plan |
| MX | MGA Plan Administrators |
| | |
| N1 | National Prescription Admin (NPA) |
| N2 | National Benefit Life Ins Co |
| N3 | National Prescription Svcs |
| N4 | NYS Auto Dealers Assoc |
| N5 | NY Farm Bureau/NYS BG |
| N6 | North Medical Comm Hlth Plan |
| N7 | National Assoc of Letter Carriers |
| N8 | Nassau Co Retiree Health Plan |
| NA | NY Dental Svcs Group |
| NB | NY School Athletic Protect/Plan |
| NC | National Casualty Co |
| ND | NY Life Insurance Co |
| NE | Nationwide General Ins Co |
| NF | First Providian Life/Health Ins |
| NG | Northcare Partners |
| NH | Nippon Life Ins |
| NI | National Ins Svcs Inc |
| NJ | Partners Health Plan |
| NK | Nationwide Life Ins Co |
| NL | New England Mutual Life Ins Co |
| NM | Meritain Health |
| NO | Nova Healthcare |
| NR | Northwestern Nat Ins Co |
| NS | New Hampshire/Vermont Health Svc |
| NT | BC/BS of North Carolina |
| NY | Health Scope Benefits Inc |
| | |
| OA | Healthnow |
| OB | HEREIU – Union |
| OX | Hotel Association of NYC |
| | |
| P1 | Principal Mutual Ins Co |
| P3 | Pharm Serv Corp of NY (PSCNY) |
| P5 | HRA |
| P6 | Humana |
| PA | Prudential |
| PB | Paul Revere Life Ins Co |
| PC | Phoenix Mutual Life Ins Co |

| Ins Cd | Description |
|---|---|
| PD | Peerless Ins Co |
| PE | Healthsource Inc |
| PG | Penn General Srv of New England Inc |
| PI | Pacific Care |
| PJ | IAA |
| PK | IBOTV Health and Welfare Fund |
| PL | Premier Health Network |
| PM | Provident Life and Accident Ins |
| PO | Provident Mut Lf Ins Co-Philadelphia |
| PP | MEDCOHEALTH |
| PR | Preferred Care |
| PT | BS Pennsylvania |
| PU | Pomco Ins |
| PW | Premera Blue Cross of Washington |
| | |
| Q3 | MDNY Healthcare |
| | |
| R1 | Catalyst Rx |
| R3 | Equitable Plan Services |
| R4 | Harrington Benefit Services |
| RA | Insurance Design Administrators |
| RB | Insurance Management Services |
| RC | International Benefit Administrator |
| RD | Island Group Administration |
| RE | Rochester Health Network |
| RF | Excellus Blue Cross Blue Shield |
| RG | HIP Rutgers Health Plan of NJ |
| RM | RMSCO Insurance |
| RX | RX West |
| | |
| S1 | BC/BS of South Carolina |
| SB | Sieba Ltd |
| SD | Susquehanna Administrators Inc |
| SE | Sears Roebuck and Company |
| SG | Security Mutual Life Ins Co |
| SH | Sentry Life Ins Co of NY |
| SL | St Lawrence/Lewis Schools Ins |
| SM | Sanus Health Plan – Medicare Risk |
| SO | Jockey Group Health Plan |
| SQ | State Farm Life and Accid Assurance |
| SS | State Mutual Lf Assurance Co/America |
| SU | Assurant Employee Benefits |
| SV | Security 65 Plan |
| SX | Sanus Health Plan |
| SZ | Suffolk Cty Employee Health Plan |
| | |
| T1 | BC/BS Texas |
| TA | Teachers Ins and Annuity Trust-Union |
| TB | Travelers |
| TC | Transamerica Ins Co |
| TD | Transworld Life Ins Co of NY |
| TE | John Alden |

| Ins Cd | Description |
|---|---|
| TL277 | Teamsters Local 277 |
| TP | Prime Therapeutics Pharmacy |
| TR | Trademark |
| TU | Travelers Health Network |
| | |
| U1 | Bakery and Confect Workers – Union |
| U2 | US Health Care – Medicare Risk |
| U9 | Industry Workers Local 424 – Union |
| UA | Union Labor Life Ins Co |
| UB | Union Mutual Life Ins Co |
| UC | Key Medical/Regence Life |
| UD | LMH Self Funded Medical Plan |
| UH | United Mutual Life Ins Co |
| UL | US Life Ins Co |
| UO | Utica Mutual Ins Co |
| UP | Union Fidelity Life of PA |
| | |
| VA | Veterans Aid |
| | |
| W1 | Wachovia Insurance |
| WA | Washington Nat Life Ins Co |
| WB | Workers Comp |
| WF | Fiserv |

| Ins Cd | Description |
|---|---|
| WI | Whole Health Ins Network |
| WJ | WJ Jones Admin Svcs |
| WL | Westchester Gen Labor Welfare Fund |
| WM | WalMart Self-Ins – Union |
| WP | William Penn Ins Co of NY |
| WR | Wellpoint Next Rx |
| WS | Wassau (NY/NJ Wrkrs Cmp Claim Off) |
| WT | Wellcare |
| WV | BC/BS West Virginia |
| | |
| XR | United Concordia Co Inc |
| | |
| | |
| ZB | Zurich Insurance Company |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Prepaid Capitation Plans (PCP)

Note:

| | |
|---|---|
| LTC | Long Term Care |
| PCMP | Physician Case Management Program |
| FHP | Family Health Plus |
| SNP | Special Needs Plan |
| MA | Medical Assistance |
| ADV | Advantage |

| MEVS Values | PCP Provider Name | Telephone Number | Plan Type |
|---|---|---|---|
| AN | Hebrew Home Hospital, Inc. (Co-op Care Plan) | (718) 379-5020 or (888) 830-5620 | Partial LTC |
| AR | Patel, Arjunj MD PC (Broome Max) | (607) 758-2543 | PCMP |
| AT | Dygert, Stephen | | PCMP |
| AW | Homefirst, Inc. | (718) 630-2560 or (877) 771-1119 | Partial LTC |
| C2 | HealthNow NY, Inc. (Community Blue) | (716) 887-6900 | Mainstream |
| C7 | Comprehensive Care Management Corporation | (718) 515-5600 or (877) 226-8500 | LTC Pace |
| CG | Capital District Physician's Health Plan | (716) 885-2261 | Mainstream |
| CV | Capital District Physician's Health Plan | (716) 885-2261 | Mainstream |
| DC | United Medical Associates | | PCMP |
| DD | Driscoll, Dan | | PCMP |
| DY | Lourdes Primary Care Assoc. (Broome Max) | (607) 778-2707 | PCMP |
| E4 | PCMP IIA Gold Choice | (716) 898-5968 | PCMP |
| E7 | Senior Care Connection | (518) 382-3290 | LTC Pace |
| FO | United Health Services Hospital | (607) 762-3173 | PCMP |
| G3 | Bhard-Waj, Gaur MD (Broome Max) | (607) 770-0004 | PCMP |
| GD | Partners in Community Care | (845) 368-5943 | Partial LTC |
| GH | Group Health, Inc. PPO | (518) 446-8010 | FHP |
| GK | GHI HMO Select A | (518) 446-8055 | Mainstream |
| GN | Guildnet | (212) 769-6200 | Partial LTC |
| H1 | Senior Health Partners, Inc. | (212) 870-4610 | Partial LTC |
| H4 | GHI HMO Select B | (518) 446-8055 | Mainstream |
| HT | HIP of Greater NY | (646) 447-5000 | Mainstream |
| HW | HIP Westchester | (646) 447-5000 | Mainstream |
| HY | HIP Nassau | (646) 447-5000 | Mainstream |
| IE | Independent Health Association | (716) 631-3086 | Mainstream |
| IN | Independent Health Association | (716) 631-3086 | Mainstream |
| IL | Independent Living for Seniors | (585) 922-2836 | LTC Pace |
| IS | Loretto HMO | (315) 469-5570 | LTC Pace |
| IX | Independent Care Systems | (212) 584-2500 | Partial LTC |
| KP | Amerigroup NY, LLC | (800) 535-2814 or (800) 563-5581 | Mainstream |
| KX | Amerigroup Community Connections | (212) 372-6942 | Partial LTC |
| LE | LI Health Partners (Broadlawn) | (516) 336-2006 | Partial LTC |
| M3 | Health Advantage Plans, Inc. (Elant Choice) | (845) 569-0500 | Partial LTC |
| M4 | Addo, Samuel (Broome Max) | (607) 729-9327 | PCMP |
| MO | United HealthCare of NY, Inc. (Met Life) | (212) 216-6824 | Mainstream |
| MR | Excellus | (585) 454-1700 | Mainstream |
| MV | MVP, Inc. (Dutchess & Ulster Counties) | (518) 388-2427 | Mainstream |
| MZ | Senior Network Health, LLC | (888) 355-4764 | Partial LTC |

| MEVS Values | PCP Provider Name | Telephone Number | Plan Type |
|---|---|---|---|
| N6 | Total Aging in Place | (716) 250-3100 | Partial LTC |
| NP | Neighborhood Health Provider PHSP | (800) 558-7970 | Mainstream |
| NW | NY Presbyterian Community PHSP, Inc. | (212) 297-5510 | Mainstream |
| OD | VidaCare, Inc. SN | (212) 337-5180 | SNP |
| OG | NY Presbyterian System Select Health SN | (866) 469-7774 | SNP |
| OM | Metroplus Partnership Care SN | (212) 597-8600 | SNP |
| OZ | Univera | (716) 857-4448 | Mainstream |
| PH | Southern Tier Priority HC | (607) 795-5215 | PCMP |
| PQ | Preferred Care | (716) 325-3920 | Mainstream |
| SA | TotalCare (Syracuse PHSP) | (315) 476-7921 | Mainstream |
| SF | HealthFirst PHSP, Inc. | (800) 580-8540 or (212) 801-6000 | Mainstream |
| SK | Suffolk Health Plan HMO | (800) 763-9132 | Mainstream |
| SP | NYS Catholic Health Plan, Inc. (Fidelis) | (800) 749-0820 | Mainstream |
| CW | NYS Catholic Health Plan, Inc. (Fidelis) | (800) 749-0820 | Mainstream |
| SR | Saeed, Azmat MD | (607) 748-7355 | PCMP |
| SL | Saeed, Azmat MD | (607) 748-7355 | PCMP |
| SY | Southern Tier Pediatrics PC | (607) 734-3252 | PCMP |
| TF | CCM Select | (718) 515-8600 | Partial LTC |
| VC | VNS Choice | (212) 609-5600 | Partial LTC |
| VG | Giordano, Vincent | | PCMP |
| WC | Wellcare of NY, Inc. | (800) 960-2530 | Mainstream |
| WH | Hudson Health Plan, Inc. | (914) 631-1611 | Mainstream |
| WK | Broome County Max Program | (607) 778-2702 | PCMP |
| WN | Wellcare of NY, Inc. | | Partial LTC |
| WR | Ramanujan Ramanujapuram | (607) 723-1676 | PCMP |
| WU | Wellcare of NY, Inc. | | MA Adv Plus |
| Y2 | Neighborhood Health Provider, LLC | (212) 883-0883 | MA Advantage |
| Y4 | Group Health Inc. | (866) 557-7300 | MA Advantage |
| Y8 | Managed Health, Inc. | (212) 801-1638 | MA Advantage |
| Y9 | Liberty Health Advantage | (866) 542-4269 | MA Advantage |
| YA | Americhoice of NY | (212) 509-5999 | MA Advantage |
| YC | HIP Health Plan of NY | (646) 447-6200 | MA Advantage |
| YD | Fidelis Dual Advantage | (718) 896-6500 | MA Advantage |
| YM | MetroPlus MA Advantage | | MA Advantage |
| YQ | HealthNow of NY | | MA Advantage |
| YR | Senior Whole Health | | MA Advantage |
| YS | Oxford Health Plan Mosaic | (914) 467-1009 | MA Advantage |
| YT | Touchstone HP (Prestige) | (888) 777-0350 | MA Advantage |
| YW | Wellcare of NY, Inc. | (212) 337-5180 | MA Advantage |
| YX | Oxford Health Plans | (914) 467-1009 | MA Advantage |
| YY | Affinity | | MA Advantage |
| 77 | Health Plus PHSP, Inc. | (718) 745-0030 | Mainstream |
| 82 | Affinity Health Plan, Inc. | (800) 553-8247 | Mainstream |
| 91 | Centercare, Inc. (Manhattan PHSP) | (800) 545-0571 | Mainstream |
| 92 | Metroplus Health Plan, Inc. | (800) 597-3380 | Mainstream |
| 98 | HIP of Greater NY | (646) 447-5000 | Mainstream |
| 99 | HIP of Greater NY | (646) 447-5000 | Mainstream |

# County/District Codes

Below is a listing of all the counties and their corresponding district codes.

| | |
|---|---|
| 01 | Albany |
| 02 | Allegany |
| 03 | Broome |
| 04 | Cattaraugus |
| 05 | Cayuga |
| 06 | Chautauqua |
| 07 | Chemung |
| 08 | Chenango |
| 09 | Clinton |
| 10 | Columbia |
| 11 | Cortland |
| 12 | Delaware |
| 13 | Dutchess |
| 14 | Erie |
| 15 | Essex |
| 16 | Franklin |
| 17 | Fulton |
| 18 | Genesee |
| 19 | Greene |
| 20 | Hamilton |
| 21 | Herkimer |
| 22 | Jefferson |
| 23 | Lewis |
| 24 | Livingston |
| 25 | Madison |
| 26 | Monroe |
| 27 | Montgomery |
| 28 | Nassau |
| 29 | Niagara |
| 30 | Oneida |
| 31 | Onondaga |
| 32 | Ontario |
| 33 | Orange |
| 34 | Orleans |
| 35 | Oswego |
| 36 | Otsego |
| 37 | Putnam |
| 38 | Rensselaer |
| 39 | Rockland |
| 40 | St. Lawrence |
| 41 | Saratoga |
| 42 | Schenectady |
| 43 | Schoharie |
| 44 | Schuyler |
| 45 | Seneca |
| 46 | Steuben |
| 47 | Suffolk |
| 48 | Sullivan |
| 49 | Tioga |
| 50 | Tompkins |
| 51 | Ulster |
| 52 | Warren |
| 53 | Washington |
| 54 | Wayne |
| 55 | Westchester |
| 56 | Wyoming |
| 57 | Yates |
| 66 | New York City |
| 97 | Office of Mental Health Administered |
| 98 | Office of Mental Retardation & Developmental Disabilities |
| 99 | Breast & Cervical Cancer Treatment Program |

# NEW YORK STATE
# MEDICAID PROGRAM

# TRANSPORTATION MANUAL

# POLICY GUIDELINES

# Table of Contents

# Section I - Requirements for Participation in Medicaid

To participate in the Medicaid Program, a provider must meet all applicable State, County and Municipal requirements for legal operation.

> Department regulation at Title 18 of the New York Code of Rules and Regulations (NYCRR) Section 505.10, which applies to transportation services, can be found at:
>
> http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Qualifications of Ambulance Providers

Only lawfully authorized ambulance services may receive reimbursement for the provision of ambulance transportation.

> An ambulance service must meet all requirements of the New York State Department of Health (NYSDOH).

An ambulance service may provide ambulette in addition to ambulance services; however, each ambulance must meet staffing and equipment regulations of a certified ambulance at all times, including occasions when an ambulance vehicle is used as an ambulette.

## Qualifications of Ambulette Providers

Only lawfully authorized ambulette services may receive reimbursement for the provision of ambulette transportation.

Ambulettes need to be in compliance with any and all New York State Department of Transportation licensing requirements.

> Ambulette drivers must be qualified under Article 19A of the New York State Department of Motor Vehicles' **Vehicle and Traffic Law.**

Some local departments of social services (LDSS) require local certification of new ambulette services prior to new ambulette companies enrolling into the Medicaid Program.

> New vendors should contact the LDSS in the area(s) in which they intend to operate to inquire about local certification requirements.

## Qualifications of Taxi/Livery Providers

To participate in the Medicaid Program, a taxi/livery provider must meet all applicable State, County and Municipal requirements for legal operation.

Taxi/livery companies must also receive support from the appropriate LDSS in the area in which the taxi/livery intends to operate in order to enroll into the Medicaid Program unless they fall under purview of a local taxi and limousine commission.

## Enrollment Requirements of Multiple Operating Locations

To receive reimbursement from the Medicaid Program, transportation providers must be enrolled in the Medicaid Program **and** have a separate provider identification number for each location furnishing supplies, care or services.

When a provider fails to disclose all operating locations to the Department, it is considered an improper practice under Department regulations and could result in administrative action that would affect the provider's participation in the Program.

> *This could also result in disallowances or penalties being assessed against the provider.*

Enrollment must be approved by the Department prior to being eligible to receive Medicaid reimbursement.

> Ambulance providers must obtain **Medicare** approval prior to submitting their application for enrollment.

# Section II - Transportation Services

Medicaid reimbursement is available to lawfully authorized transportation providers for transportation furnished to recipients whenever necessary to obtain medical care.

> *Transportation services are limited to the provision of passenger-occupied transportation to or from Medicaid covered services.*

The Medicaid Program must assure that necessary transportation is available to recipients. The requirement is based on the recognition that unless needy individuals can actually get to and from providers of services, the entire goal of the Medicaid Program is inhibited at the start.

This assurance requirement means that Medicaid will consider assisting with the costs of transportation when the costs of transportation become a barrier to accessing necessary medical care and services covered under the Medicaid Program. The decision to assist with the costs of transportation is called the prior authorization process.

The Medicaid Program will cover the costs of all modes of transportation, when necessary, as well as the necessary transportation expenses incurred by the Medicaid recipient who must travel an extraordinary distance.

**The costs of emergency ambulance transportation do not require prior authorization. All other modes of transportation, while available to a recipient, need to be prior authorized by the appropriate prior authorization official prior to payment by the Medicaid Program.**

Approved requests for prior authorization are communicated to the transportation provider via a roster, which lists the information necessary to submit a valid claim to the Medicaid Program.

> The information on the claim must match the information on the prior authorization as one condition for the claim to be paid.

Transportation services are distinguished by three separate modes of transportation:

- Ambulance (ground and air),
- Ambulette (wheelchair van) and
- Taxi/Livery.

The mode of transportation used by a recipient may involve a medical practitioner, who is best able to determine the most appropriate mode. Each of these categories of

providers may provide single, episodic transports. Ambulette and taxi/livery providers may also provide group ride transports to and from a daily program.

**The Medicaid Program intends to authorize transports using the *least costly, medically-appropriate* mode of transport.**

> If a Medicaid-eligible client uses the public transit system for the events of daily living, then transportation for the client should be requested at a mode of transportation no higher than that of the public transit system.

Amounts for reimbursement of transportation services are established by the county of recipient fiscal responsibility, usually the LDSS in the county of recipient residence.

## Record Keeping Requirements

Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid recipients Medicaid-covered services will only be made for services documented in contemporaneous records.

Documentation shall include the following:

- The recipient's name and Medicaid identification number;
- The origination of the trip;
- The destination of the trip;
- The date and time of service; and,
- The name of the driver transporting the recipient.

For auditing purposes, Medicaid recipient records must be maintained and be available to authorized officials for six (6) years following the date of payment.

## Ambulance Services

Non-emergency and emergency ambulance services are covered by the Medicaid Program.

In non-emergency situations, a determination must be made by the LDSS or State agency of fiscal responsibility whether the use of an ambulance, rather than a non-specialized mode such as ambulette service, taxi service, livery service or public transportation, is medically necessary.

> The recipient’s physician, physician’s assistant, or nurse practitioner **must** order non-emergency ambulance services.

In cases of emergencies, emergency medical services are provided without regard to the patient's ability to pay and no order is required. Payment will only be made if transportation was provided to the client.

Ambulance services are bound by the operating authority granted them by the NYSDOH.

Ambulance services whose operating authority has been revoked by the NYSDOH will be disenrolled from the Medicaid Program, thus precluding payment from the Medicaid fiscal agent.

Ambulance services must maintain the NYSDOH-required Patient Care Report as a condition of Medicaid reimbursement.

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

## Billing for Advance Life Support Assist (ALS)/Fly-Car Service

Advanced Life Support Assist/Fly-Car Service, as defined in the definition section of this manual, is an emergency advanced life support response in conjunction with an emergency ambulance transport provided by another ambulance service.

This type of service should not be billed at the regular ALS reimbursement rate, which is established for those providers who deliver ALS and transport the patient in the provider's vehicle.

**ALS-assist services can only be billed if the LDSS has established a unique reimbursement amount for this service.**

## Billing for Advanced Life Support services vs. Basic Life Support Services

Ambulance companies may not bill Medicaid for both basic life support services (BLS) and advanced life support services when advanced life support service is provided. This type of billing is incorrect for those counties that have established separate rates for advanced life support and basic life support services**.**

> *The provision of advanced life support services **includes** the delivery of basic life support services.*

When an ambulance is sent to the scene and it provides advanced life support services, only that service may be billed to the Medicaid Program.

## Ambulance Transportation of Neonatal (Newborn) Infants to Regional Perinatal Centers

Neonatal (newborn) ambulance transportation services (surface only) of critically ill newborn infants between community hospitals and Regional Perinatal Centers (RPCs) are the responsibility of each RPC.

> ***The RPC will arrange for necessary ambulance services and be reimbursed directly by Medicaid for the costs of that ambulance transportation service.***

Regionalization of neonatal services into a single system of care was established by the NYSDOH to assure that each infant who requires intensive care receives it as expeditiously as possible in the appropriate facility. These facilities (RPC's) have affiliation agreements with community hospitals within their region.

> The RPC is responsible for finding a RPC hospital bed and arranging for neonatal ambulance transportation of the critically ill infant to the RPC. At the time of discharge the RPC will arrange for the transfer of the infant back to the community hospital.

LDSS staff will not accept requests from hospitals for prior authorization of this ambulance transportation service. The service will be authorized by the RPC, and they will make payment to the ambulance company.

**Please note that neither air transportation of neonatal infants nor maternal transportation is covered under the Regional Perinatal Center Program.**

## Air Ambulance Guidelines and Reimbursement

In determining whether air ambulance transportation reimbursement will be authorized the following critical guidelines can be used:

- The patient has a catastrophic, life-threatening illness;
- The patient is at a hospital that is unable to properly manage the medical condition;
- The patient needs to be transported to a uniquely qualified hospital facility;
- Ground transport to the uniquely qualified hospital facility is not appropriate for the patient;
- Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; and,
- Life-support equipment and advanced medical care is necessary during transport.

A case-by-case prepayment review, by the local district's Medical Director of the ambulance provider's *Pre-hospital Care Report*, will enable the LDSS to determine if these guidelines were met.

## Transportation of a Hospital Inpatient

When a Medicaid recipient is admitted to a hospital (under Article 28 of the Public Health Law), the hospital is reimbursed their inpatient rate, Diagnostic Related Group (DRG) and per diem, which **includes all transportation services for the patient**.

If the admitting hospital sends a Medicaid inpatient (round trip) to another hospital for purposes of obtaining a diagnostic or therapeutic service, **the original admitting hospital is responsible for the provision of the transportation services.**

The admitting hospital is responsible for the reimbursement of the ambulance or other transportation service for the transport of the patient.

For example: An admitting hospital arranges for the round trip transport of a Medicaid inpatient to another hospital for a diagnostic test. The admitting hospital should reimburse the transportation provider for the transport of the patient.

## Fixed-Wing Air Ambulance

The following fixed-wing air ambulance services are reimbursable:

- Base Rate (Lift-off/call-out amount);
- Patient Loaded Mileage;
- Physician (when ordered by hospital);
- Respiratory Therapist
  (When ordered by the hospital, and only when the hospital is unable to supply);
- Destination Ground Ambulance Charge
  (To be charged only when the destination is out of state)

The District of fiscal responsibility, or the Department, should be contacted for the current rates.

The established rates assume the following:

- The provider will be responsible for advanced life support services, inclusive of all services and necessary equipment, except as noted above;

- The provider will be responsible for paying the charges of ground ambulance at the destination end of the trip only when the destination is out-of-state.

  When the destination is within New York State, the Destination Ground Ambulance charge can be billed to the Medicaid Program by the provider. Ground ambulance charges for trips within New York State will be submitted at the established basic life support rate on a fee-for-service basis by the ground ambulance company providing transportation between the airport and the hospital;

- These amounts will be applied regardless of time or date of transport, i.e., day, night, weekend and holiday;

- The provider will not seek or accept additional reimbursement from the Medicaid recipient (under any circumstances when billing the Medicaid Program), other individuals, or a facility, except when a third party insurance is billed, in which case the provider will be reimbursed as follows:

  **a)** For patients covered by Medicare, Medicaid will pay the coinsurance and deductible amount.

  **b)** For patients covered by other third parties, Medicaid will pay the coinsurance and deductible amount up to the Medicaid rate. If the insurance company pays more than the Medicaid rate, Medicaid will not make any additional reimbursement.

  **c)** When an air ambulance bill is rejected by a third party insurance with the determination that the trip was medically **unnecessary**, the provider will not bill the Medicaid Program. If the third party insurance pays at the ground ambulance rate, Medicaid will reimburse as described in a) or b).

- The mileage rate will be applied only to patient **loaded** miles, i.e., those miles during which the patient is on the aircraft.

  Unloaded mileage, i.e., those miles covered while the aircraft is in transit to receive the patient or while the aircraft is returning to base, will not be charged.

## Helicopter Air Ambulance

The following helicopter air ambulance services are reimbursable:

- Lift-off from base and

- Patient Occupied Flight Time.

The District of fiscal responsibility, or the Department, should be contacted for the current rates.

## Transport from an Emergency Room to a Psychiatric Center

An ambulance service may be requested to transfer a Medicaid recipient, undergoing an acute episode of mental illness, from an emergency room to a psychiatric hospital.

Hospital and law enforcement officials, when dealing with such a person, must use an ambulance vehicle in transporting that person to acute psychiatric care; they do **not** use non-emergency modes of transportation such as ambulette or taxi.

A transport of a mentally ill individual under the above conditions is an emergency ambulance transport as defined in this Manual.

This transportation ordered by hospital or law enforcement staff qualifies as an emergency ambulance transport; i.e., the patient is in immediate need of acute psychiatric care that is to be provided at the psychiatric hospital.

> These ambulance transports should be treated as an emergency transport. Prior authorization from the LDSS is not required.

## Transport from an Emergency Room to a Trauma, Cardiac Care or Burn Center

An ambulance service may be requested to transfer a Medicaid recipient from an emergency room to a regional trauma, cardiac or burn center.

> These ambulance transports should be treated as an emergency transport. Prior authorization from the LDSS is not required.

## Ambulance Transportation by Voluntary Ambulance Services

Voluntary ambulance services may bill the Medicaid Program for the transportation of a Medicaid recipient when the following conditions are met:

- The Voluntary Ambulance Service has been authorized by the LDSS to bill Medicaid at a rate established for this transportation; and,
- The Voluntary Ambulance Service first bills all other third party insurance companies.

## Rules for Ordering Non-emergency Ambulance Transportation

A request for prior authorization for non-emergency ambulance transportation must be supported by the order of an ordering practitioner who is the Medicaid recipient's attending physician, physician's assistant or nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation services on behalf of the ordering practitioner.

Non-emergency ambulance transportation may be ordered when the recipient is in need of services that can only be administered by an ambulance service.
The ordering practitioner must note in the recipient's patient record the recipient's condition that qualifies the use of non-emergency ambulance services.

An ordering practitioner, or facilities and programs ordering on the practitioner's behalf, which do not meet the above rules, may be sanctioned according to the regulations established by the DOH.

## Medicare Involvement (18 NYCRR Section 360-7.3)

Medicare, in many instances, is obligated to pay for ambulance transportation for patients with Medicare Part B coverage.

Medicare guidelines require that the patient be suffering from an illness or injury which contraindicates transportation by any other means. This requirement is presumed to be met in the following instances when the patient:

- Was transported in an emergency situation, e.g.; as a result of accident, injury, or acute illness;
- Needed to be restrained;
- Was unconscious or in shock;
- Required oxygen or other emergency treatment on the way to the destination;
- Had to remain immobile because of a fracture that had not been set or the possibility of a fracture;
- Sustained an acute stroke or myocardial infarction;
- Was experiencing severe hemorrhage;
- Was bed confined before and after the ambulance trip; or
- Could be moved only by stretcher.

Ambulance services shall submit a claim to the Medicare carrier when transportation has been provided to a Medicare eligible person.

Upon approval by Medicare of the claim, a claim may be submitted to Medicaid.

Claims for ambulance services will be reviewed by the Medicaid Program to determine if the recipient has Medicare and if the provider billed Medicare prior to submission to Medicaid.

When an ambulance service has been instructed by the Medicare carrier **not** to submit a claim to the carrier for the ambulance transportation of a person covered under Medicare Part B because Medicare does not cover that particular service (for example, the transport of a person to a physician's office), the ambulance service must submit evidence of such instructions to the Prior Authorization Official.

The Prior Authorization Official will then determine if Medicaid reimbursement will be authorized.

Ambulance services are covered under Medicare Part A when a hospital inpatient is transported to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital.

The ambulance service is included in the hospital's Medicare Part A payment.

In such situations when an ambulance service transports a hospital inpatient covered under Medicare to medical care not available at the hospital, the ambulance service shall seek reimbursement from the hospital.

The provider shall **not** seek authorization from the Prior Authorization Official nor shall the provider submit a claim to Medicaid for reimbursement.

Reimbursement for ambulance transportation of a hospital inpatient covered only under Medicaid to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital may be included in the hospital's reimbursement or may be available as a separately billed service.

The provider shall contact the Prior Authorization Official to determine whether reimbursement should be sought from the hospital or claimed through the eMedNY.

In general, when an original admitting hospital sends a Medicaid inpatient to another hospital for purposes of obtaining a diagnostic or therapeutic service not available in the admitting hospital, the original hospital is responsible for the costs of transportation. Neither hospital may bill the Medicaid Program separately for the transportation services.

The hospital should reimburse the ambulance or other transportation service for the transport of the patient, as the Medicaid inpatient rate is inclusive of all services provided to the Medicaid patient.

The transport will not be authorized by the LDSS nor paid fee-for-service.

When a patient covered under Medicare is discharged from one hospital and is transported from that hospital to a second hospital for purposes of admission as an inpatient to the second hospital, the ambulance service is paid for under Medicare Part B. The provider shall submit a claim to the Medicare carrier as instructed above.

Medicaid will not reimburse claims that are not approved by Medicare or other insurance when a determination has been made that the transportation by ambulance was not medically necessary.

Regulation 18 NYCRR Section 360-7.3 applicable to this policy can be found at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm

## Ambulette Services

Medicaid reimbursement is available to lawfully authorized ambulette providers for ambulette transportation furnished to recipients whenever necessary to obtain medical care. Transportation services are limited to the provision of passenger occupied transportation to or from Medicaid covered services.

The LDSS or State agency of fiscal responsibility must make a determination whether the use of an ambulette, rather than a non-specialized mode such as taxi service, livery service or public transportation, is medically necessary.

Ambulette services are bound by the operating authority granted them by the New York State Department of Transportation (NYSDOT). In accordance with NYSDOT procedures, each service is given the authority to operate within a certain geographic area. Within the prescribed geographic area, transportation is to be "open to the public."

Service is not to be withheld between any points within the boundaries of the service's operating authority when the ambulette service is open for business.

Thus, an ambulette service participating in the NYSDOH's Medicaid Program at the current Medicaid rate may not refuse Medicaid transportation within the ambulette service's area of operation.

Furthermore, refusal to provide transportation within your operating authority constitutes a violation of New York State Transportation Law Section 146 which reads

> *"...It shall be the duty of every motor carrier to provide adequate service, equipment and facilities under such rules and regulations as the Commissioner may prescribe."*

Ambulette services found guilty of violating Section 146 of the New York State Transportation Law will face fines and possible revocation of operation authority, as determined by NYSDOT.

Ambulette services whose operating authority has been revoked by the NYSDOT will be removed from the NYSDOH's Medicaid Program, thus precluding Medicaid payment.

**An ambulette may not be used as an ambulance to provide emergency medical services.**

> An ambulette may transport a person who requires oxygen, as long as the passenger *self-administers* the oxygen.
>
> Ambulette service personnel *may not* administer oxygen.
>
> An ambulette is allowed to provide stretcher services when the vehicle is appropriately configured.

An ambulette may also provide taxi service (curb-to-curb service). The only requirement that ambulettes need to meet for this service is the proper authority and license to operate as an ambulette.

We do not require the ambulette to be licensed as a taxi service; it operates as an ambulette providing taxi service.

## Group Rides and Mileage Reimbursement

All ambulette or van providers who transport more than one Medicaid recipient at the same time in the ambulette or van and who are reimbursed for vehicular mileage should claim only for the actual number of miles from the first pick-up of a Medicaid recipient to the final destination and drop-off of all recipients.

> For example, Ace Company's reimbursement has been established at $20 per one-way pickup rate plus $1.00 per loaded mile.
>
> On Monday, Ace is authorized to transport Mrs. Jones to her Friday morning clinic appointment, a one-way mileage of 13 miles.
>
> On Tuesday, Ace is authorized to transport Mr. Frank to the same clinic at the same time, a one-way mileage of 7 miles.

Due to living on the same route, Ace will pick up both recipients in the same vehicle.

Ace should claim the base rate and the mileage rate of 13 miles for Mrs. Jones, who is the first one picked up. Ace should only claim the base rate for Mr. Frank. Even though Ace has been authorized 7 miles for Mr. Frank, since these 7 miles duplicate concurrent miles already paid for under Mrs. Jones claim, Ace should not claim for these 7 miles.

If you are reimbursed on a one-way pickup rate only (no mileage reimbursement), regardless of the number of miles transported, this policy does **NOT** apply to your transportation.

Some NYC recipients reside in counties outside NYC.

For these recipients who reside outside NYC and travel outside NYC, the rule for ordering mileage reimbursement is the same as that which applies to all other recipients of that county.

## Reporting of Vehicle and Driver License Numbers

Transportation providers billing for ambulette services (category of service 0602) are required to:

- Include the **driver license number** of the individual driving the vehicle on their claim.

- Include the **license plate number** of the vehicle used to transport the Medicaid client on their claim.

*If a different driver and/or vehicle returns the recipient from the medical appointment, the license number of the driver and vehicle used for the origination of the trip should be reported on the claim.*

## Annual Ambulette Survey

Providers of ambulette service are required to submit vehicle information on an annual basis. Each ambulette provider must disclose in writing information concerning those vehicles currently owned or leased by the provider.

The information will be requested in each January edition of the *Medicaid Update*.

An ambulette provider who fails to disclose the requested information may have its participation in the Medicaid Program terminated.

## Personal Assistance, Escorts and Carry-Downs by an Ambulette Service

There is no separate reimbursement for the escort of a Medicaid recipient. Necessary escorts are to be provided by the ambulette service at no additional charge.

Personal assistance by the staff of the ambulette company is **required** by the Medicaid Program and consists of the rendering of physical assistance to the ambulatory and non-ambulatory (wheelchair bound) recipient in:

- walking, climbing or descending stairs, ramps, curbs or other obstacles,
- opening or closing doors,
- accessing an ambulette vehicle, and
- the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

There is no enhanced reimbursement for a person traveling in a wheelchair or a person needing to be carried down steps.

## Stretcher Transportation Provided by an Ambulette Service

Stretcher transportation of a Medicaid recipient by an ambulette service is allowed under the Medicaid Program.

> The ambulette service is not allowed to provide any medical service to the recipient.

Stretcher transport is appropriate when the recipient is not in need of any medical care or service enroute to one's destination and the recipient must be transported in a recumbent position.

> The ambulette vehicle must be configured to be able to hold a stretcher securely during transport.

The ambulette service should establish a reimbursement amount with the LDSS before beginning this service.

## Rules for Ordering Ambulette Transportation (NYCRR Section 505.10(c)(2))

A request for prior authorization for transportation by ambulette or invalid coach must be supported by the order of an ordering practitioner who is the Medicaid recipient's:

- attending physician,

- physician's assistant,
- nurse practitioner,
- dentist,
- optometrist,
- podiatrist or
- other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order ambulette transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The recipient needs to be transported in a recumbent position and the ambulette service is able to transport a stretcher;
- The recipient is wheelchair-bound and is unable to use a taxi, livery service, bus or private vehicle;
- The recipient has a disabling physical condition, which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle;
- An otherwise ambulatory recipient requires radiation therapy, chemotherapy, or dialysis treatments, which result in a disabling physical condition after treatment, making the recipient unable to access transportation without personal assistance provided by an ambulette service.

Ambulette transportation may be ordered if:

- The recipient has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette service; and,
- The ordering practitioner certifies in a manner designated by and submitted to the department that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and there is a need for ambulette service;

- The ordering practitioner must note in the recipient's patient record the recipient's condition, which qualifies the use of ambulette services.

An ordering practitioner, or facilities and programs ordering on the practitioner's behalf, which do not meet the above rules, may be sanctioned according to Section 515.3 of the regulations established by the Department of Health.

Department of Heath Regulations governing this policy can be found at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Taxi/Livery Services

### Prior Authorization

Prior Authorization of taxi/livery services is required to ensure that a recipient uses the means of transportation most appropriate to his medical needs.

Orders for taxi/livery services shall be made in advance by either the recipient or the recipient's medical practitioner.

> **In New York City, *all* livery transportation must be ordered by the recipient's medical practitioner.**

### Rules for Ordering New York City Livery Transportation

A request for prior authorization for transportation by New York City livery must be supported by the order of an ordering practitioner who is the Medicaid recipient's attending physician, physician's assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner designated by the district and approved by the department.

> A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

## Day Treatment/Day Program

Day treatment/day program transportation is unique, in that this transportation can be provided by an ambulance, ambulette, taxi, or livery provider.

> The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

> Providers of transportation to a day treatment/day program must adhere to the same requirements listed above for their specific provider category.

# Section III - Basis of Payment for Services Provided

Reimbursement rates are established by the local department of social services (LDSS), the transportation coordinator acting on behalf of the LDSS or the State agency that is fiscally responsible for the Medicaid client (Department of Health, Office of Mental Health (OMH), or Office of Mental Retardation and Developmental Disabilities (OMRDD)).

> The transportation provider must contact the Transportation Unit staff at the local department of social services or State agency for procedure codes and rates.

The extent to which transportation services are paid through the Medicaid fiscal agent varies from one LDSS to another.

> In order to determine who to bill, please consult the fiscally responsible LDSS, the OMH (County Code 97) or the OMRDD (County Code 98).

Reimbursement is provided to lawfully authorized transportation providers (ambulance, ambulette, taxi, and livery) for passenger-occupied services to and from Medicaid covered-services for Medicaid payment and local payment.

> Payment rates for coordinated transportation must be obtained from the transportation coordinator.

**Payment will not be made for unauthorized services.**

## Prior Authorization

**Prior Authorization is *required* for all non-emergency transportation**. This includes ambulance, ambulette, livery, taxi and group transports such as day treatment/day program.

> The prior authorization of non-emergency transportation services is required to ensure that the recipient uses the mode of transportation most appropriate to the recipient's medical needs and that an adequate but less costly transportation plan cannot be arranged.

***Payment will not be made for non-emergency transports if the transportation vendor does not receive authorization for the transport.***

Prior authorization must be obtained from one of the following fiscally responsible entities:

- The LDSS (county codes 01–57);
- The New York State OMH (county code 97);

- The New York State OMRDD (county code 98);
- The New York State Department of Health (county code 99); or,
- The Medicaid fiscal agent, Computer Sciences Corporation, for non-emergency transports of NYC Medicaid recipients (County 66).

Procedures for obtaining prior authorization differ from one county to another.

> It is important to contact the transportation staff in the recipients' fiscally responsible local department of social services, including the OMH, the OMRDD and DOH, to determine the appropriate procedures to be followed.

In general, prior authorization is obtained by either the ordering provider (physician, physician's assistant or nurse practitioner) or other medical personnel designated by the ordering provider.

> If authorization is granted, the transportation provider will receive notification of authorization and sufficient recipient and destination information to allow the provider to render transportation services.

Prior authorization usually must be obtained before each trip (or round trip) taken by the recipient.

> If a recipient requires regular transportation due to extended treatment (such as dialysis) and the recipient's medical appointment is at the same location, and if the same provider is to transport the recipient, prior authorization may be granted for an extended period as determined by the local department of social services.

Whenever such prior authorization for non-emergency transportation is not obtained, reimbursement will be denied. *However, prior authorization does not guarantee payment.*

> For example, provider eligibility and recipient eligibility requirements that are not met may result in the denial of a claim payment.

Comprehensive billing information can be found in the Transportation Billing Guidelines manual, available online at:

http://www.emedny.org/ProviderManuals/Transportation/index.html.

## Weekend and Holiday Transportation

When a recipient requires an appointment for a medical service on a weekend or holiday, and the appointment is made on that same weekend or holiday, authorization may not be obtained until the next business day.

In such cases, the transportation provider receives the transportation request directly from the ordering practitioner's office or medical facility at which the recipient has the medical appointment.

The transportation provider shall contact the ordering provider for NYC recipients or the fiscally responsible local department of social services for all other recipients on the next business day in order to obtain authorization for services rendered.

All authorization guidelines must be followed before authorization is granted to the transportation provider.

## Mileage Within New York City

Mileage within urban areas, such as New York City, is difficult to control. Therefore, New York City has established fixed reimbursement amounts for trips occurring within the five boroughs encompassing the City for **all modes of transportation.**

*When a trip occurs within any of the five boroughs, i.e., Queens to Manhattan, mileage should not be ordered.*

When a New York City recipient requires long-distance transportation, i.e., Manhattan to Suffolk County, mileage may be ordered, **beginning at the City limits**.

For long distance trips that occur outside the five boroughs, NYC does allow for mileage reimbursement in addition to the fixed payment amounts, beginning at the city limits.

NYC Medicaid recipients are generally expected to obtain their medical care and services within five miles from their residence. This five-mile geographic area is considered the common medical marketing area (CMMA).

Transportation can be ordered for trips greater than five miles from the recipient's residence, when the medical care or service is unavailable within the CMMA.

The difficulty orderers of transportation face is when a recipient resides in a borough contiguous with Westchester (Bronx) or Nassau County (Queens), and the recipient is traveling into the other county for medical care and service.

In these situations, mileage can be ordered when the transport is over five miles from the recipient's residence.

If the one-way trip is greater than five miles, the mileage begins at the NYC/other county border (not the recipient's residence).

For example, if a recipient travels ten miles from Queens to Nassau County, and two miles are traveled in Queens and eight additional miles are traveled in Nassau County, then the one-way mileage is eight miles.

Transports to the medical care or service within five miles of the recipient's residence should never receive a mileage add-on.

## Ordering Non-Emergency Transportation for Restricted Recipients

The LDSS and the Department may restrict a recipient's access to Medicaid covered care and services if, upon review, it is found that the recipient has received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies (NYCRR Section 360-6.4).

In such cases, the LDSS and the Department may require that the recipient access specific types of medical care and services through a designated primary provider or providers.

The State medical review team designated by the Department performs recipient utilization reviews and identifies candidates for the Recipient Restriction Program.

The primary provider is a health care provider enrolled in the Medicaid Program who has agreed to oversee the health care needs of the restricted recipient. The primary provider will provide and/or direct all medically necessary care and services for which the recipient is eligible, within the provider's category of service or expertise.

Primary providers include:

- Physicians,
- Clinics,
- Inpatient Hospitals,
- Pharmacies,
- Podiatrists,
- DME dealers,
- Dentists, and
- Dental clinics.

***When a recipient is restricted to a primary physician or primary clinic and a primary dentist or primary dental clinic, the primary physician or primary clinic will be the only allowed orderer of transportation services*.**

This applies to all modes of non-emergency transportation, including ambulance, ambulette, taxi, livery, public transportation and day treatment/program.

This includes cases where the recipient's primary physician or clinic has referred the patient to another provider. In such situations ordering transportation services remains the responsibility of the primary physician or clinic.

Transportation providers should use the Medicaid ID Number of the primary physician or clinic when obtaining eligibility information via MEVS as well as when submitting claims.

Department of Heath Regulations governing this policy can be found at:

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Transportation Rosters

Transportation providers and ordering providers who either render or order transportation services for Medicaid eligible recipients will receive a Transportation Roster on a weekly basis.

Transportation prior authorizations will appear on your weekly rosters as they are generated by the local district or Computer Sciences Corporation for New York City Medicaid recipients.

In the majority of cases (especially for New York City recipients), the authorizations will be for up to six months.

These prior authorizations will only appear on the roster when they are first entered into the system, or if changes are made.

The Roster lists all prior authorized transportation services requested by an ordering provider.

The Transportation Provider’s Roster lists the ordering provider for which prior authorization was issued as well as the information required to complete a claim form for billing purposes.

Rosters received by ordering providers list prior authorized transportation services that have been ordered by the provider during a weekly period. The Roster sent to the ordering provider verifies those services that have been prior authorized and lists the transportation provider identification number of the authorized provider.

The following information is listed on the weekly rosters:

- **Client** information including:
  - Name;
  - Date of birth;
  - Sex;
  - Medicaid Client Identification Number.
- **Authorization** information including:
  - Authorized period of service;
  - Prior authorization number;
  - Procedure code;
  - Occasions of services authorized.

## Description of Fields on Transportation Roster

Transportation rosters will be produced by the Department on a weekly basis.

When a LDSS enters a prior authorization into the prior authorization system, it will appear on the roster that you will receive weekly.

All data on the roster will appear as it was data-entered.

You should check the data to verify its accuracy prior to billing for the service.

If there are any errors in the data, contact the LDSS responsible for the data entry as soon as possible and have them make the necessary corrections.

The following is an explanation of each field on the roster:

**PROCESS DATE**
This is the date that the roster was produced by eMedNY.

**BILLING PROVIDER ID**
This is the Medicaid provider ID for your transportation company. This is followed by the master file name of your transportation company.

**CLIENT ID**
This is the client's Medicaid identification number. This number has two alphabetic characters in the first two positions, then five numbers, and the last character is alphabetic.

*Example:* AB12345C

**RECIPIENT NAME**
This is the recipient name as it appears on master file, last name first. Your rosters will appear in alphabetic order by recipient name.

**DATE OF BIRTH**
This is the recipient's date of birth as it appears on the master file.

**SEX**
This is the recipient's sex as it appears on the master file.

**CNTY FISC RESP**
This is the county who retains fiscal responsibility of the client. A list of county codes is available in the MEVS Provider Manual, online at:

http://www.emedny.org/ProviderManuals/AllProviders/supplemental.html#MEVSPM.

**ORDERING PROVIDER ID**
This is the eight-digit provider ID of the Medicaid provider who ordered the transportation.

If it is the State License Number for the provider, the number would appear as eleven digits with the first three being the profession code.

**PROCEDURE CODE**
This is the procedure code for the trip. The procedure codes for each LDSS vary and can be obtained from the LDSS transportation unit.

**PRIOR AUTHORIZATION NUMBER**
This is the eleven-digit prior authorization number for this specific trip or trips. This number must be placed on your claim in the appropriate field in order to secure payment.

**DETERMINATION**
Codes in this field indicate the authorization status.

**RSN REJECTED**
If the determination is “rejected”, then the rejection code will appear in this field.

**PERIOD OF SERVICE FROM/TO**
The beginning and ending dates of service are found in this field. If the prior authorization is for one day, the dates will be the same.

**APPROVED QUANTITY**
The number of units of service that a provider has been authorized to provide to a client.

**APPROVED AMOUNT**
This is the maximum dollar amount that a provider can be paid for providing a unit of service to a Medicaid client. This amount will be $0.00 unless the prior authorization agent has approved a specific amount per unit.

**RENDERED QUANTITY**
This is the total number of units and claims rendered for this prior authorization.

**TOTAL NUMBER OF ENTRIES ON THIS ROSTER**
This number is the total number of prior authorization lines of service appearing on this roster.

## Subcontracting Transports

Medicaid rules allow only the provider of service (or the billing agent for that provider) to submit claims for services rendered.

Due to mechanical breakdowns or other circumstances, transportation providers will face times when the number of available vehicles does not meet the demand for services. At these times, providers may choose to lease vehicles from another operator, or subcontract with another provider:

- It is expected that the leased/subcontracted vehicle will have current required inspection stickers.
- The driver of the leased/subcontracted vehicle must be in compliance with all applicable regulations.
- The provider must maintain adequate records to support billing for Medicaid regardless of whether the trip is subcontracted.

In essence, you remain the provider of service and the transportation service provided is clearly identified with your company. When these conditions are met, then you are allowed to bill Medicaid for rendered transportation services.

As long as the vehicle and driver used to perform the transportation service are properly licensed by all regulatory agencies and the trip can be documented showing the actual driver and the actual vehicle that performed the trip, then the use of any duly licensed vehicle and driver to perform the transportation service is permitted.

The practice of subcontracting trips to another provider for a certain percentage or amount of the resulting Medicaid reimbursement, without identifying the vehicle and driver, is prohibited under Medicaid.

This ad hoc subcontracting practice subverts Medicaid's role to insure that only enrolled providers who meet all regulatory requirements are allowed to deliver Medicaid transportation services.

The practice of assigning trips to another provider, for the purpose of billing and receiving a percentage on each paid claim, is prohibited. A provider must show, when audited, in addition to billing for the service, an accounting of the cost associated with that trip (i.e., dispatching, fuel, insurance, office expense, etc.).

## Situations Where Medicaid Will Not Provide Reimbursement

Reimbursement is not provided for any mode of transportation when any of the following situations exist:

- The consumer is not eligible for Medicaid on the date of service;
- Prior authorization for the non-emergency transport is not secured;
- The claim is not submitted to the Medicaid Program in the required format with the required information;
- The medical service to which the transportation occurred is not covered by the Medicaid program (i.e., Medicaid will only consider payment of transportation services to and from care and services covered under the Medicaid Program);
- The transportation service is available to others in the community without charge;
- The recipient is restricted to a primary provider, and the claim uses another ordering provider Medicaid ID number;
- There is a rate listed but effort is never made to collect the fee from individuals who are not enrolled in the Medicaid Program;
- The provider is out of compliance with licensure requirements;

- The service is provided by a medical institution or program and the cost is included in that institution's or program's Medicaid rate; or

- Transportation services are not actually provided to a Medicaid recipient.

# Section IV - Definitions

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

## Advanced Life Support Services

Advanced life support (ALS) services are those ambulance services in which the treatment provided is ***invasive*** to the patient inclusive and above the level of care provided by a NYS Certified EMT. Such treatment includes:

- Advanced prehospital patient assessment and appropriate transport destination determination;
- The initiation and monitoring of intravenous (IV) fluids;
- Cardiac monitoring (ECG);
- Intubation/insertion of an airway tube**,** manual ventilations or the monitoring of an electronic ventilation device;
- Manual defibrillation and/or electric pacing of the patient's heart;
- Administration or monitoring of medications given by mouth, injection or IV drip as prescribed by protocol and/or a physician's order.
- Communication with a physician and the transmittal of patient data such as the ECG.

## Advanced Life Support Assist/Fly-Car Service

An advanced life support assist/fly-car service is an emergency advanced life support response in conjunction with an emergency ambulance transport provided by another ambulance service.

In this type of response, an ambulance service employee with ALS training and equipped with ALS equipment is dispatched to the emergency scene to assist the primary ambulance service by providing necessary ALS in which the primary ambulance service personnel have no training.

## Ambulance

An ambulance is a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

## Ambulance Service

An ambulance service is any entity, as defined in Section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat, or

other form of transportation to or from facilities providing hospital services and which is certified or registered by the NYSDOH as an ambulance service.

## Ambulette or Invalid Coach

Ambulette or invalid coach is a special-purpose vehicle designed and equipped to provide non-emergency care that has either wheelchair-carrying capacity or the ability to carry disabled individuals.

## Ambulette Service

An ambulette service is an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care.

> An ambulette service provides the invalid, infirm or disabled with **personal assistance**.

## Basic Life Support Services

Basic life support (BLS) services are ambulance services in which the treatment provided to the patient is ***noninvasive*** and/or within the scope of practice for a NYS certified EMT Basic.

These services include the following services and all other services that are not listed as Advanced Life Support (ALS) Services:

- Use of anti-shock trousers (treatment of shock);
- Monitoring of a patient's blood pressure;
- Administration of oxygen;
- Administration of nebulized Albuterol;
- Administration of Epinephrine Auto-Injector (Epi-Pen) for allergic reactions;
- Control of bleeding;
- Splinting fractures;
- Cardiopulmonary resuscitation;
- Delivery of babies.

## Common Medical Marketing Area

The common medical marketing area is the geographic area from which a community customarily obtains its medical care and services.

## Community

A community is either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

## Conditional Liability

Conditional liability is the responsibility of the prior authorization official for making payment only for transportation services which are provided to Medicaid eligible individuals in accordance with the requirements of Title 18 (the regulations of the New York State Department of Social Services).

## Day Treatment Program or Continuing Treatment Program

A day treatment program or continuing treatment program is a planned combination of diagnostic, treatment and rehabilitative services certified by the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

## Department Established Rate

A department established rate is the rate for any given mode of transportation that the department has determined will ensure the efficient provision of appropriate transportation to Medicaid recipients in order for the recipients to obtain necessary medical care or services.

## Emergency Medical Services

Emergency medical services are services for the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency.

> Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed.

## Local Department of Social Services

The local department of social services (LDSS) is the locality that authorizes the Medicaid recipients' eligibility for Medicaid and is fiscally responsible for the payment of the recipients' medical bills.

> There are 58 LDSS in New York State, including the five boroughs of New York City, which comprise one LDSS.

## Locally Established Rate

The locally established rate is the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for Medicaid recipients in order for the recipients to obtain necessary medical care or services.

## Locally Prevailing Rate

The locally prevailing rate is a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third-party payer, and which is charged to all persons using that mode of transportation in a given community.

## New York State Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD)

OMH and OMRDD are two State agencies operate as Counties of fiscal responsibility in New York State. OMH is district 97 and OMRDD is district 98. They are responsible for the authorization of non-emergency transportation services for recipients for which they retain fiscal responsibility.

> Emergency ambulance transportation services are also authorized by these two agencies for their recipients.

## Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is the provision of ambulance transportation for the purpose of obtaining necessary medical care or services by a Medicaid recipient whose medical condition requires transportation in a recumbent position.

Non-emergency ambulance transportation is transportation of a pre-planned nature where the patient must be transported on a stretcher or requires the administration of life support equipment, such as oxygen, by trained medical personnel.

## Ordering Practitioner

An ordering practitioner is the Medicaid recipient's attending physician or other medical practitioner who has not been excluded from or denied enrollment in the Medicaid program and who is requesting transportation on behalf of the Medicaid recipient in order for the Medicaid recipient to receive medical care or services covered under Medicaid.

The ordering practitioner is responsible for initially determining when transportation to a particular medical care or service is medically necessary.

## Personal Assistance

The provision of physical assistance by the provider of ambulette services or the provider's employee to Medicaid recipient for the purpose of assuring safe access to and from the recipient's place of residence, ambulette vehicle or Medicaid-covered health service provider's place of business.

Personal assistance is the rendering of physical assistance to the recipient in walking, climbing or descending stairs, ramps, curbs or other obstacles, opening or closing doors, accessing an ambulette vehicle, the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance.

**A recipient who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.**

## Prior Authorization

A prior authorization official's determination that payment for transportation is essential in order for a Medicaid recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

## Prior Authorization Official

A prior authorization official is an official from the LDSS, the OMH, the OMRDD or their designated agents.

## Transportation Attendant

A transportation attendant is any individual authorized by the prior authorization official to assist the Medicaid recipient in receiving safe transportation.

## Transportation Expenses

Transportation expenses are the costs of transportation services; and the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

## Transportation Services

Transportation services are services by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and transportation attendant to accompany the Medicaid recipient, if necessary.

Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Medicaid recipient's family.

## Vendor

A vendor is a lawfully authorized provider of transportation services who is either enrolled in the Medicaid program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a local department of social services or other agent designated by the Department.

> The term vendor does not mean a Medicaid recipient or other individual who transports a Medicaid recipient by means of a private vehicle.

# FEE SCHEDULE

# NEW YORK STATE
# MEDICAID TRANSPORTATION

# NYS Medicaid Transportation Procedure Code Schedule

## Ambulance

| Procedure Code | Description |
|---|---|
| A0422 | Advanced Life Support or Basic Life Support Oxygen and Oxygen Supplies Life Sustaining Situation |
| A0420 | Wait Time (ALS or BLS) One Half Hour Increments |
| A0424 | Extra attendant, ALS or BLS (Requires Medical Review) |
| A0425 | Ground Mileage per Statute Mile |
| A0426 | Advanced Life Support, Non-Emergency, Level 1 (ALS1) |
| A0427 | Advanced Life Support, Emergency, Level 1 (ALS1 Emergency) |
| A0428 | Basic Life Support, Non-Emergency (BLS) |
| A0429 | Basic Life Support, Emergency (BLS Emergency) |
| A0430 | Conventional Air Services, Transport, One Way (Fixed Wing) |
| A0431 | Conventional Air Services, Transport, One Way (Rotary Wing) |
| A0432 | Paramedic Intercept |
| A0433 | Advanced Life Support, Level 2 (ALS2) |
| A0434 | Specialty Care Transport (SCT) |
| A0435 | Fixed Wing air mileage, per statute mile |
| A0436 | Rotary Wing air mileage, per statute mile |
| A0999 | Unassigned |

## Ambulette/Wheelchair Van

| Procedure Code | Description |
|---|---|
| NY100 | One way trip inside common medical marketing area |
| NY101 | One way evening, weekend, holiday |
| NY102 | One way outside common medical marketing area |
| NY103 | Mileage |
| NY104 | Roundtrip |
| NY105 | Additional recipients in vehicle at the same time |
| NY106 | One Way to recurring appointments, i.e., dialysis |
| NY107 | Add-on for long distance trip |
| NY108 | Add-on for exceptional travel situations requiring increased reimbursement (i.e., carrydown) |
| NY109 | Attendant |
| NY110 | Attendant evening, weekend, holiday |
| NY111 | Stretcher: One way inside common medical marketing area |
| NY112 | Stretcher: One way outside common medical marketing area |
| NY113 | Stretcher: Add-on for exceptional travel situations requiring increased reimbursement |
| NY114 | Stretcher: Roundtrip |
| NY115 | Stretcher: Mileage |
| NY116 | Drug store stop/other/extra stop |
| NY117 | Tolls |
| NY118 | Ambulette Used as Taxi/Livery |
| NY119 | Ambulette Used as Taxi/Livery: ambulatory |
| NY120 | Multi-purpose vehicle used as ambulette/taxi/livery |
| NY121 | Ambulette as Taxi/Livery: mileage |
| NY122 | Ambulette as Taxi/Livery: outside common medical marketing area |
| NY123 | Ambulette as Taxi/Livery: additional recipients in vehicle |
| NY124 | Group Ride: one way per person ambulatory |
| NY125 | Group Ride: one way per person wheelchair |
| NY126 | Group Ride: extra recipient traveling at the same time |
| NY127 | Group Ride: outside common medical marketing area |
| NY128 | Group Ride: outside county |
| NY129 | Group Ride: Roundtrip |
| NY130 | Group Ride: attendant |
| NY131 | Group Ride: Mileage |
| NY132 | Specific Provider Reimbursement |
| NY133 | Specific Provider Reimbursement |

## Ambulette/Wheelchair Van…continued

| Procedure Code | Description |
|---|---|
| NY134 | Specific Provider Reimbursement |
| NY135 | Mileage: Specific Provider Reimbursement |
| NY136 | Mileage: Specific Provider Reimbursement |
| NY137 | Mileage: Specific Provider Reimbursement |
| NY138 | Mileage: Specific Provider Reimbursement |
| NY139 | Stretcher: Specific Provider Reimbursement |
| NY140 | Stretcher: Specific Provider Reimbursement |
| NY199 | Unassigned available for extraordinary transports |

## Taxi/Livery/Van

| Procedure Code | Description |
|---|---|
| NY200 | One way inside common medical marketing area |
| NY201 | One way evening, weekend, holiday |
| NY202 | One way outside common medical marketing area |
| NY203 | Roundtrip |
| NY204 | Inside County |
| NY205 | Outside county |
| NY206 | Mileage |
| NY207 | Additional recipients in vehicle at same time |
| NY208 | Regularly recurring trip, i.e., dialysis |
| NY209 | Attendant |
| NY210 | Add-on for long distance trip |
| NY211 | Add-on for exceptional travel situations requiring increased reimbursement |
| NY212 | Group Ride: One way inside common medical marketing area |
| NY213 | Group Ride: One way outside common medical marketing area |
| NY214 | Group Ride: Roundtrip |
| NY215 | Group Ride: Inside county |
| NY216 | Group Ride: Outside county |
| NY217 | Group Ride: One way ambulatory per person |
| NY218 | Group Ride: One way wheelchair per person |
| NY219 | Group Ride: One way ambulatory additional recipient in vehicle at same time |
| NY220 | Group Ride: One way wheelchair additional recipient in vehicle at same time |
| NY221 | Group Ride: Mileage |
| NY222 | Group Ride: Ambulatory Mileage |
| NY223 | Group Ride: Wheelchair mileage |
| NY224 | Group Ride: Attendant |
| NY225 | Group Ride: to Medical Appointment |
| NY226 | Drugstore stop/extra stop |
| NY227 | Tolls |
| NY228 | Group Ride One way zone 1 or county specific |
| NY229 | Group Ride One way zone 2 or county specific |
| NY230 | Group Ride One way zone 3 or county specific |
| NY231 | Group Ride One way zone 4 or county specific |
| NY232 | Group Ride One way zone 5 or county specific |
| NY233 | Group Ride One way zone 6 or county specific |
| NY234 | Specific Provider Reimbursement |
| NY235 | Specific Provider Reimbursement |
| NY298 | Group Ride: Unassigned for extraordinary transports |
| NY299 | Taxi/Livery: Unassigned for extraordinary transports |

For information on Medicaid transportation reimbursement amounts and procedure codes, please contact the Local Department of Social Services (LDSS) Medicaid transportation staff.

LDSS contact information is located in the **Information for All Providers – Inquiry** manual, available online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

# NEW YORK STATE
# MEDICAID PROGRAM

# TRANSPORTATION

# BILLING GUIDELINES

# TABLE OF CONTENTS

# Section I – Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Transportation providers and should be used by the provider as an instructional as well as a reference tool.

# Section II – Claims Submission

Transportation providers can submit their claims to NYS Medicaid in electronic or paper formats.

## Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Transportation providers who choose to submit their Medicaid claims electronically are required to use the HIPAA 837 Professional (837P) transaction. In addition to this document, direct billers may also refer to the sources listed below to comply with the NYS Medicaid requirements:

- **HIPAA 837P Implementation Guide (IG)** – A document that explains the proper use of the 837P standards and program specifications. This document is available at www.wpc-edi.com/hipaa.

- **NYS Medicaid 837P and 837P Non-Emergency Transportation Companion Guides (CG)** are subsets of the IG that provide specific instructions on the NYS Medicaid requirements for the 837P transaction.

- **NYS Medicaid Technical Supplementary Companion Guide** provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are testing requirements, error report information, and communication specifications.

These documents are available at www.emedny.org by clicking on the link to the web page below:

**eMedNY Companion Guides and Sample Files**

## Pre-requirements for the Submission of Electronic Claims

Before being able to start submitting electronic claims to NYS Medicaid, providers need the following:

- An Electronic/Paper Transmitter Identification Number (ETIN)
- A Certification Statement
- A User ID and password
- A Trading Partner Agreement
- Testing

**ETIN**
This is a submitter identifier issued by the eMedNY Contractor that must be used in every electronic submission to NYS Medicaid. ETINs may be issued to an individual provider or provider group (if they are direct billers) and to service bureaus or clearinghouses.

The ETIN application is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

**Certification Statement**
All providers, either direct billers or those who billed through a service bureau or clearinghouse, must file a notarized Certification Statement with NYS Medicaid for each ETIN used for the electronic billing.

The Certification Statement is good for one year, after which it needs to be renewed for electronic billing continuity under a specific ETIN. Failure to renew the Certification Statement for a specific ETIN will result in claim rejection.

The Certification Statement is available on the third page of the ETIN application at www.emedny.org or can be accessed by clicking on the link above.

**User ID and Password**
Electronic submitters need a user ID and password to access the NYS Medicaid eMedNY system through one of the communication methods available. The user ID and password are issued to the submitter at the time of enrollment in one of the communication methods. The method used to apply for a User ID varies depending on the communication method chosen by the provider. For example: An ePACES User ID is assigned systematically via email while an FTP User ID is assigned after the submission of a Security Packet B.

**Trading Partner Agreement**
This document addresses certain requirements applicable to the electronic exchange of information and data associated with health care transactions. The NYS Medicaid Trading Partner Agreement is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

**Testing**
Direct billers (either individual providers or service bureaus/clearinghouses that bill for multiple providers) are encouraged to submit production tests to CSC before they start submitting Medicaid claims for the first time after enrollment or any time they update their systems or start using a new system. This testing will assist providers in identifying errors in their system and allow for corrections before they submit actual claims. Information and instructions regarding testing are available at www.emedny.org by clicking on the link to the web page below:

**eMedNY Companion Guides and Sample Files**

## Communication Methods

The following communication methods are available for submission of electronic claims to NYS Medicaid:

- ePACES
- eMedNY eXchange
- FTP
- CPU to CPU
- eMedNY Gateway

## ePACES

NYS Medicaid provides ePACES, a HIPAA-compliant web-based application that is customized for specific transactions, including the 837P. ePACES, which is provided free of charge, is ideal for providers with small to medium claim volume.

The requirements for using ePACES include:

- An ETIN and Certification Statement should be obtained prior to enrollment
- Internet Explorer 4.01 and above or Netscape 4.7 and above
- Internet browser that supports 128-bit encryption and cookies
- Minimum connection speed of 56K
- An accessible email address

The following transactions can be submitted via ePACES:

- 270/271 - Eligibility Benefit Inquiry and Response
- 276/277 - Claim Status Request and Response
- 278 - Prior Approval/Prior Authorization/Service Authorization Request and Response
- 837 - Dental, Professional, and Institutional Claims

ePACES also features the **real time claim submission** functionality under the 837 Professional transaction, which allows immediate adjudication of the claim. When this functionality is used, a claim adjudication status response is sent to the submitter shortly after submission.

To take advantage of ePACES, providers need to follow an enrollment process. Additional enrollment information is available at www.emedny.org by clicking on the link to the web page below:

**Self Help**

### eMedNY eXchange

The eMedNY eXchange works like email; users are assigned an inbox and they are able to send and receive transaction files in an email-like fashion. Transaction files are attached and sent to eMedNY for processing, and the responses are delivered to the user's inbox so they can be detached and saved on the user's computer. **For security reasons, the eMedNY eXchange is accessible only through the eMedNY website at** www.emedny.org.

The eMedNY eXchange only accepts HIPAA-compliant transactions.

Access to the eMedNY eXchange is obtained through an enrollment process. To enroll in eXchange, you must first complete enrollment in ePACES and at least one login attempt must be successful.

### FTP

File Transfer Protocol (FTP) is the standard process for batch authorization transmissions. FTP allows users to transfer files from their computer to another computer. FTP is strictly a dial-up connection.

FTP access is obtained through an enrollment process. To obtain a user name and password, you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

### CPU to CPU

This method consists of a direct connection established between the submitter and the processor, and it is most suitable for high volume submitters. For additional information regarding this access method, please contact the eMedNY Call Center at 800-343-9000.

### eMedNY Gateway

This is a dial-up access method. It requires the use of the user ID assigned at the time of enrollment and a password. eMedNY Gateway access is obtained through an enrollment process. To obtain a user name and password you must complete and return a Security Packet B. The Security Packet B is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

**Note: For questions regarding ePACES, eXchange, FTP, CPU to CPU, or eMedNY Gateway connections, call the eMedNY Call Center at 800-343-9000.**

## Paper Claims

Transportation providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A). To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

**Transportation - Sample Claim**

### General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below as possible:

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. For example:

| Written As | Intended As | Interpreted As | |
|---|---|---|---|
| 6.00 | 6.00 | 6.60 | → Zero interpreted as six |

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. For example:

| Written As | Intended As | Interpreted As |
|---|---|---|
| 2 | 2 | 7 → Two interpreted as seven |
| 3 | 3 | 2 → Three interpreted as two |

- Characters should not touch each other. For example:

| Written As | Intended As | Interpreted As |
|---|---|---|
| 23 | 23 | illegible → Entry cannot be interpreted properly |

- Do not write in between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections (i.e. information written over correction fluid or crossed out information). If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

**COMPUTER SCIENCES CORPORATION**
**P.O. Box 4601**
**Rensselaer, NY 12144-4601**

# Claim Form A-eMedNY-000201

To view the eMedNY-000201 claim form, please click on the link provided below. The displayed claim form is a sample and the information it contains is for illustration purposes only.

**Transportation - Sample Claim**

## General Information About the eMedNY-000201

Shaded fields are not required to be completed **unless noted otherwise**. Therefore, shaded fields that are not required to be completed in any circumstance are not listed in the instructions that follow.

Most claim form fields have been sized to contain the exact number of characters for the required information. However, some fields have been sized to accommodate potential future changes. For example, the Provider ID number has more spaces than the current number of characters for the required information. In this case, the entry must be **right justified (unless otherwise noted in the field instructions)**; that is, the extra spaces must be left blank at the left side of the box. For example, Provider ID number 02345678 should be entered as follows:

| | | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|

# Billing Instructions for Transportation Services

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Transportation providers. Although the instructions that follow are based on the eMedNY-000201 paper claim form, they are also intended as a guideline for electronic billers who should refer to these instructions for finding out what information they need to provide in their claims, what codes they need to use, etc.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

## Field by Field Instructions for Claim Form A-eMedNY-000201

**Header Section: Fields 1 through 24B**

***The information entered in the Header Section of the claim form (fields 1 through 24B) must apply to all of the claim lines entered in the Encounter Section of the form.***

**PROVIDER ID NUMBER (Field 1)**

The Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program.

Enter the provider's ID number, the provider's name and correspondence address in this field.

**Note: For emergency services only; until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.**

**BILLING DATE (Field 2)**

Leave this field blank.

**GROUP ID NUMBER (Field 3)**

Leave this field blank.

## LOCATOR CODE (Field 4)

Locator codes are assigned to the provider for each service address registered at the time of enrollment in the Medicaid program or at anytime, afterwards, that a new location is added.

Locator codes 001 and 002 are for administrative use only and are not to be entered in this field. If the provider renders services at **one** location only, enter locator code 003. If the provider renders service to Medicaid recipients at **more than one** location, the entry may be 003 or a higher locator code. Enter the locator code that corresponds to the address where the service was performed.

**Notes:**

- **The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section on the web page for this manual.**

- **For emergency services only; until NYS Medicaid is able to accept and process claims using the National Provider ID (NPI), providers must continue to report their assigned NYS Medicaid Provider ID number. Providers will be notified by NYS Medicaid when to begin reporting NPI information.**

## SA EXCP CODE [Service Authorization Exception Code] (Field 5)

Leave this field blank.

***Fields 6 and 6A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.***

## ADJUSTMENT/VOID CODE (Field 6)

**Leave this field blank when submitting an original claim or resubmission of a denied claim.**

- If submitting an **adjustment** (replacement) to a previously paid claim, enter **X** or the value **7** in the A box.

- If submitting a **void** to a previously paid claim, enter **X** or the value **8** in the V box.

## ORIGINAL CLAIM REFERENCE NUMBER (Field 6A)

**Leave this field blank when submitting an original claim or resubmission of a denied claim.**

If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record. For example, a document/record containing a single service date/procedure combination will be assigned a unique, single TCN; a document/record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claim lines submitted under that document/record.

**Adjustment**
An adjustment may be submitted to accomplish any of the following purposes:

- To change information contained in one or more claims submitted on a previously paid TCN

- To cancel one or more claim lines submitted on a previously paid TCN (except if the TCN contained one single claim line or if all the claim lines contained in the TCN are to be voided)

### *Adjustment to Change Information*

If an adjustment is submitted to correct information on one or more claim lines sharing the same TCN, follow the instructions below:

- The **Provider ID number**, the **Group ID number**, and the **Patient's Medicaid ID number** must not be adjusted.

- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable).

- The adjustment must contain all claim lines originally submitted in the same document/record (all claim lines with the same TCN) and all applicable fields must be completed with the necessary changes.

The adjustment will cause the correction of the adjusted information in the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the TCN based on the adjusted information.

**Example:**

TCN 0709819876543200 is shared by three individual claim lines. This TCN was paid on April 18, 2007. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Refer to Figures 1A and 1B for an illustration of this example.

## Figure 1A: Original Claim Form

## NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | | | | 0 0 3 | | A V | |

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| A B 1 2 3 4 5 C | 0 5 2 0 1 9 9 0 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | A B 1 2 3 4 5 | |

**ABC Transportation**
**100 Broadway**
**Anytown, New York 11111**

| 12. PRIMARY DIAGNOSIS CODE | 12A. SECONDARY | EMER-GENCY? 13. Y N | POSSIBLE DISABILITY? 13A. Y N | FAMILY PLANNING 13B. Y N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ CTHP 16. Y N | RECIPIENT OTHER INSURANCE CODE 17. | ABORTSTER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 1 1 | | | | | 0 1 2 3 4 5 6 7 | | Mark Lane, M.D. |

| 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY ▶ | 24A. SIGNATURE | 24B. DIAGNOSIS |
|---|---|---|---|---|---|
| | | | | | |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 4 | 0 5 | 0 7 | N Y 2 1 1 1 | 1 3 | | | | | | | | 1 1 4.3 0 | | | | | |
| | 0 4 | 0 7 | 0 7 | N Y 2 1 1 1 | 1 3 | | | | | | | | 1 1 4.3 0 | | | | | |
| | 0 4 | 0 9 | 0 7 | N Y 2 1 1 1 | 1 3 | | | | | | | | 1 1 4.3 0 | | | | | |
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| 33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**DO NOT STAPLE IN BARCODE AREA**

[redacted]

**CERTIFICATION**
**(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)**

| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 04 | 10 | 07 |

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

## Figure 1B: Adjustment

# NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | | | | 0 0 3 | | 7 V | 0 7 0 9 8 1 9 8 7 6 5 4 3 2 0 0 |

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| A B 1 2 3 4 5 C | 0 5 2 0 1 9 9 0 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | A B 1 2 3 4 5 | |

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**100 Broadway**
**Anytown, New York 11111**

| DIAGNOSIS CODE 12. PRIMARY | 12A. SECONDARY | EMER-GENCY? 13. Y N | POSSIBLE DISABILITY? 13A. Y N | FAMILY PLANNING 13B. Y N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ C/THP 16. Y N | RECIPIENT OTHER INSURANCE CODE 17. | ABORT STER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 1 1 | | | | | 0 1 2 3 4 5 6 7 | | Mark Lane, M.D. |

| 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE | 24B. DIAGNOSIS |
|---|---|---|---|---|---|
| | | | | ▶ | |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 4 | 0 5 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | | | | | |
| | 0 4 | 0 7 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | | | | | |
| | 0 4 | 1 0 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | | | | | |
| | | | | | | | | | | | | | | | | | | |
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| 33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36. |
|---|---|---|---|---|---|---|---|
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| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 06 | 05 | 07 |

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

### *Adjustment to Cancel One or More Claims Originally Submitted on the Same Document/Record (TCN)*

An adjustment should be submitted to cancel or void one or more individual claim lines that were originally submitted on the same document/record and share the same TCN. The following instructions must be followed:

- The adjustment must be submitted in a new claim form (copy of the original form is unacceptable).

- The adjustment must contain all claim lines submitted in the original document (all claim lines with the same TCN) **except for the claim(s) line(s) to be voided**; these claim lines must be omitted in the adjustment. All applicable fields must be completed.

The adjustment will cause the cancellation of the omitted individual claim lines from the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the new TCN (Adjustment) based on the adjusted information.

**Example:**

TCN 0709818765432100 contained three individual claim lines, which were paid on April 18, 2007. Later it was determined that one of the claims was incorrectly billed since the service was never rendered. The claim line for that service must be cancelled to reimburse Medicaid for the overpayment. An adjustment should be submitted. Refer to Figures 2A and 2B for an illustration of this example.

## Figure 2A: Original Claim

## NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 01234567 | | | | | 003 | | A V | |

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**Anytown, New York 11111**

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| AB123456C | 05201990 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | AB123456 | |

| DIAGNOSIS CODE 12. PRIMARY | 12A. SECONDARY | EMER-GENCY? 13. Y | N | POSSIBLE DISABILITY? 13A. Y | N | FAMILY PLANNING 13B. Y | N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ C/THP 16. Y | N | RECIPIENT OTHER INSURANCE CODE 17. | ABORT STER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| . | . | | | | | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 11 | | | | | 0123456 7 | | Mark Lane, M.D. |
| | | 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE ▶ | 24B. DIAGNOSIS . |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 04 | 05 | 07 | NY211 | 13 | | | | | | | | 14.30 | . | . | . | . | . |
| | 04 | 07 | 07 | NY211 | 13 | | | | | | | | 14.30 | . | . | . | . | . |
| | 04 | 09 | 07 | NY211 | 13 | | | | | | | | 14.30 | . | . | . | . | . |
| | | | | | | | | | | | | | . | . | . | . | . | . |
| | | | | | | | | | | | | | . | . | . | . | . | . |
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| | | | | | | | | | | | | | . | . | . | . | . | . |
| 33. CASE MGR | | | | TOTALS | | | | | | | | | 34. . | 35. . | 35A. . | 35B. . | 35C. . | 36. . |

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(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 04 | 10 | 07 |

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

## Figure 2B: Adjustment

## NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | | | | 0 0 3 | | 7 V | 0 7 0 9 8 1 8 7 6 5 4 3 2 1 0 0 |

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| A B 1 2 3 4 5 C | 0 5 2 0 1 9 9 0 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | A B 1 2 3 4 5 | |

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Anytown, New York 11111

| DIAGNOSIS CODE 12. PRIMARY | 12A. SECONDARY | EMER-GENCY? 13. Y N | POSSIBLE DISABILITY? 13A. Y N | FAMILY PLANNING 13B. Y N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ C/THP 16. Y N | RECIPIENT OTHER INSURANCE CODE 17. | ABORT STER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| . | . | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 1 1 | | | | | 0 1 2 3 4 5 6 7 | | Mark Lane, M.D. |
| | | 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE ▶ | 24B. DIAGNOSIS |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 4 | 0 7 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
| | 0 4 | 0 9 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
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| 33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36. |
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| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 06 | 05 | 07 |

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

## Void

A void is submitted to nullify **all** individual claim lines originally submitted on the same document/record and sharing the same TCN.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form (copy of the original form is unacceptable).

- The void must contain all the claim lines to be cancelled and all applicable fields must be completed.

Voids cause the cancellation of the original TCN history records and payment.

**Example:**

TCN 0709811234567800 contained two claim lines, which were paid on April 18, 2007. Later, the provider became aware that the patient had another insurance coverage. The other insurance was billed and paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Refer to Figures 3A and 3B for an illustration of this example.

## Figure 3A: Original Claim Form

## NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | | | | 0 0 3 | | A V | |

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| A B 1 2 3 4 5 C | 0 5 2 0 1 9 9 0 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | A B 1 2 3 4 5 | |

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| DIAGNOSIS CODE 12. PRIMARY | 12A. SECONDARY | EMER-GENCY? 13. Y N | POSSIBLE DISABILITY? 13A. Y N | FAMILY PLANNING 13B. Y N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ C/THP 16. Y N | RECIPIENT OTHER INSURANCE CODE 17. | ABORT STER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| . | . | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 1 1 | | | | | 0 1 2 3 4 5 6 7 | | Mark Lane, M.D. |

| 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE ▶ | 24B. DIAGNOSIS |
|---|---|---|---|---|---|
| | | | | | . |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 4 | 0 4 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
| | 0 4 | 0 5 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
| | | | | | | | | | | | | | . | . | . | . | . | . |
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| | 33. CASE MGR | | | TOTALS | | | | | | | | | 34. . | 35. . | 35A. . | 35B. . | 35C. . | 36. . |

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CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 04 | 05 | 07 |

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

## Figure 3B: Void

## NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM CLAIM FORM A

| 1. PROVIDER ID NUMBER | 2. BILLING DATE MO | DAY | YR | 3. GROUP ID NUMBER | 4. LOCATOR CODE | 5. SA EXCP CODE | ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM 6. CODE | 6A. ORIGINAL CLAIM REFERENCE NUMBER |
|---|---|---|---|---|---|---|---|---|
| 0 1 2 3 4 5 6 7 | | | | | 0 0 3 | | A V 8 | 0 7 0 9 8 1 1 2 3 4 5 6 7 8 0 0 |

| 7. RECIPIENT ID NUMBER | 8. DATE OF BIRTH | 8A. SEX M | F | 9. RECIPIENT NAME – FIRST | 10. OFFICE ACCOUNT NUMBER (OPTIONAL) | 11. OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| A B 1 2 3 4 5 C | 0 5 2 0 1 9 9 0 | | X | Jane | | |
| | | | | 9A. RECIPIENT NAME – LAST: Smith | A B 1 2 3 4 5 | |

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**Anytown, New York 11111**

| DIAGNOSIS CODE 12. PRIMARY | 12A. SECONDARY | EMER-GENCY? 13. Y N | POSSIBLE DISABILITY? 13A. Y N | FAMILY PLANNING 13B. Y N | ACCIDENT CODE 14. | PATIENT STATUS CODE 15. | EPSDT/ C/THP 16. Y N | RECIPIENT OTHER INSURANCE CODE 17. | ABORT STER CODE 18. | 19. PRIOR APPROVAL NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|
| . | . | | | | | | | | | |

| PLACE OF SERVICE 20. CODE | 20A. ADDRESS | 21. SERVICE PROVIDER ID/LICENSE NUMBER | 21A. PROF CD | 21B. NAME | 23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER | 23A. PROF CD | 23B. NAME |
|---|---|---|---|---|---|---|---|
| 1 1 | | | | | 0 1 2 3 4 5 6 7 | | Mark Lane, M.D. |

| 22. OTHER IREFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | 22A. PROF CD | 22B. NAME | 24.SHARED HEALTH FACILITY ONLY | 24A. SIGNATURE | 24B. DIAGNOSIS |
|---|---|---|---|---|---|
| | | | | ▶ | . |

| | 25. DATE OF SERVICE MO | DAY | YR | 26. PROCEDURE CODE | 27. TIMES PERFORMED | 28. ORAL CAVITY | DENTAL 29. TOOTH | 29A. SURFACE M | I/O | D | F/B | L | 30. AMOUNT CHARGED | MEDICARE 31. CO-INSURANCE | 31A. DEDUCTIBLE | 31B. CO-PAY | 31C. PAID | 32. OTHER INSURANCE PAID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 4 | 0 4 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
| | 0 4 | 0 5 | 0 7 | N Y 2 1 1 | 1 3 | | | | | | | | 1 4.3 0 | . | . | . | . | . |
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| 33. CASE MGR | TOTALS | 34. | 35. | 35A. | 35B. | 35C. | 36. |
|---|---|---|---|---|---|---|---|
| | | . | . | . | . | . | . |

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

| 37. SIGNATURE | 37A. COUNTY* | 38. DATE MO | DAY | YR |
|---|---|---|---|---|
| James Strong | | 06 | 05 | 07 |

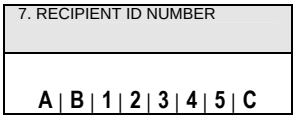
*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

***Fields 7-9A require Recipient (Client) information that may be obtained from the ordering provider, local district, or prior approval roster.***

## RECIPIENT ID NUMBER (Field 7)

Enter the patient's identification number (Client ID number). Medicaid Client ID numbers are assigned by NYS Medicaid and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.

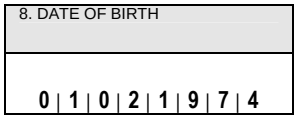
**Example:**




## DATE OF BIRTH (Field 8)

Enter the patient's birth date. The birth date must be in the format MMDDYYYY.

**Example:** Mary Brandon was born on January 2, 1974.




## SEX (Field 8A)

Place an 'X' in the appropriate box to indicate the patient's sex.

## RECIPIENT NAME (Fields 9 and 9A)

Enter the patient's first name in Field 9 and the last name in Field 9A.

## OFFICE ACCOUNT NUMBER (OPTIONAL) (Field 10)

For record-keeping purposes, the provider may choose to identify a recipient by using an Office Account number. This field can accommodate up to 20 alphanumeric characters. If an Office Account number is indicated on the claim form, it will be returned on the Remittance Advice. Using an Office Account number can be helpful for locating accounts when there is a question on the recipient identification.

## DIAGNOSIS CODE [Primary/Secondary] (Fields 12 and 12A)

Leave this field blank.

## EMERGENCY (Field 13)

### Ambulance
Enter an X in the Yes box only when the service is related to an emergency (the patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling condition); otherwise leave this field blank.

### Ambulette, Taxis, Day Program, and Livery
Leave this field blank.

## POSSIBLE DISABILITY (Field 13A)

Leave this field blank.

## FAMILY PLANNING (Field 13B)

Leave this field blank.

## ACCIDENT CODE (Field 14)

If applicable, enter the appropriate code from Appendix A-Code Sets to indicate whether the service rendered to the recipient was for a condition resulting from an accident or a crime.

## PATIENT STATUS CODE (Field 15)

Leave this field blank.

## EPSDT C/THP CODE (Field 16)

Leave this field blank.

## RECIPIENT OTHER INSURANCE CODE (Field 17)

Leave this field blank.

## ABORTION/STERILIZATION CODE (Field 18)

Leave this field blank.

## PRIOR APPROVAL NUMBER (Field 19)

Enter in this field the 11-digit prior authorization number obtained by the ordering provider and assigned for this service by the appropriate agency of the New York State Department of Health. The prior authorization number appears on the Transportation roster. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval.

**Note: For further information about prior authorization, please refer to the Prior Approval Guidelines available at www.emedny.org by clicking on the link to the web page below:**

**Transportation Manual**

## PLACE OF SERVICE CODE (Field 20)

Leave this field blank.

## PLACE OF SERVICE ADDRESS (Field 20A)

Leave this field blank.

## SERVICE PROVIDER [Medicaid] ID/LICENSE NUMBER (Field 21)

**Ambulette Services Only**
Enter the license plate number of the vehicle used for transport in this field.

**Example:**

| 21. SERVICE PROVIDER ID/LICENSE NUMBER |
| --- |
| \| \| \| N \| Y \| S \| 1 \| 2 \| 3 \| 4 |

## PROF CD [Profession Code - Service Provider] (Field 21A)

Leave this field blank.

## NAME [Service Provider] (Field 21B)

Leave this field blank.

## OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER (Field 22)

**Ambulette Services Only**
Enter the nine-character driver's license number of the transport driver in this field.

**Example:** The driver's license number is 123456789.

| 22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER |
|---|
| \| 1 \| 2 \| 3 \| 4 \| 5 \| 6 \| 7 \| 8 \| 9 |

**Note: When reporting an out of state driver's license number with more than nine (9) characters, only the first nine (9) characters should be reported (Refer to Example 1 below). If a driver's license number contains fewer than nine (9) characters, the entry must be right justified and zero-filled to complete the nine (9) characters (Refer to Example 2 below).**

**Example 1:** The driver's license number is A123456789B.

| 22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER |
|---|
| \| A \| 1 \| 2 \| 3 \| 4 \| 5 \| 6 \| 7 \| 8 |

**Example 2:** The driver's license number is 3456789.

| 22. OTHER (REFERRING/ORDERING) PROVIDER ID/LICENSE NUMBER |
|---|
| \| 0 \| 0 \| 3 \| 4 \| 5 \| 6 \| 7 \| 8 \| 9 |

## PROF CD [Profession Code - Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

## NAME [Other Referring/Ordering Provider] (Field 22B)

Leave this field blank.

## ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER (Field 23)

**Ambulance, Ambulette, and Livery**
Non-emergency transportation services must be ordered by a medical practitioner or facility. Enter the ordering provider's Medicaid ID number in this field. If the ordering provider is not enrolled in Medicaid, enter his/her license number. This information is provided by the ordering provider and appears on the Transportation Prior Authorization roster.

***Instructions for Entering a License Number***
If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. If the out of state license number is less than 6 characters, enter zeros after the state code and before the license number to make an 8 character number. Please refer to Appendix A-Code Sets for the Post Office state abbreviations.

When providing non-emergency transportation services to a patient who is restricted to a primary physician or clinic, the **Medicaid ID** number of the patient's primary physician or clinic must be entered in this field. **The license number of the primary physician is not acceptable in this case.**

**Note: For emergency Ambulance services, leave this field blank.**

**Taxi and Day Program**
Leave this field blank except when providing services to a patient who is restricted to a primary physician or clinic. In such case, the **Medicaid ID** number of the patient's primary physician or clinic must be entered in this field. **The license number of the primary physician is not acceptable in this case.**

**PROF CD [Profession Code - Ordering/Referring Provider] (Field 23A)**

**Ambulance, Ambulette, and Livery**
If a license number is indicated in Field 23, the Profession Code that identifies the ordering provider profession must be entered in this field. Profession Codes are avaliable at www.emedny.org by clicking on the link to the web site below:

**eMedNY Crosswalks**

**NAME [Ordering/Referring Provider] (Field 23B)**

If fields 23 and 23A were completed, enter the ordering provider's name in this field.

**SHARED HEALTH FACILITY ONLY (Field 24A)**

Leave this field blank.

## Encounter Section: Fields 25 through 32

***The claim form can accommodate up to nine encounters with a single patient if all the information in the Header Section of the claim (Fields 1–24B) applies to all the encounters.***

## DATE OF SERVICE (Field 25)

Enter the date on which the service was rendered in the format MM/DD/YY.

**Example**: July 1, 2007 = 07/01/07

**Note: A service date must be entered for each procedure code listed.**

## PROCEDURE CODE (Field 26)

This code identifies the type of service that was rendered to the patient. Enter the appropriate five-character Procedure Code in this field. Leave the two spaces to the right of the solid line blank as in the sample below.

**Example:**

| 26. PROCEDURE CODE | |
|---|---|
| N \| Y \| 2 \| 1 \| 1 | \| |

**Note: Procedure codes, definitions, prior authorization requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link below under Procedure Codes and Fee Schedule:**

**Transportation Manual**

## TIMES PERFORMED (Field 27)

If a trip was performed more than one time on the same date of service, enter the number of round trips in this field.

If applicable, enter the number of miles associated with a given transportation service.

## ORAL CAVITY (Field 28)

Leave this field blank.

## TOOTH CODE (Field 29)

Leave this field blank.

## SURFACE (Field 29A)

Leave this field blank.

## AMOUNT CHARGED (Field 30)

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge. When billing for a round trip, multiply the fee for a one-way trip by two and enter the amount in this field.

***Fields 31, 31A, 31B, and 31C are only applicable if the recipient is also a Medicare beneficiary.***

**Ambulance**
It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

If the provider knows that the service rendered **is not covered** by Medicare, contact the local district for approval to enter zero in field 31C and to receive prior authorization for Medicaid reimbursement for the service.

If the service **is covered** by Medicare but Medicare denies **approval** (for example, the service was not medically necessary), Medicaid will also deny payment.

**Notes:**

- **All non-emergency transportation services involving Medicare coverage do not require prior authorization unless the actual service is not covered by Medicare. The provider must first bill Medicare.**

- **Only when the actual service is not covered by Medicare will Medicaid consider prior authorization.**

**Ambulette, Taxi, Day Program, and Livery**
Enter 0.00 in these fields.

## MEDICARE CO-INSURANCE (Field 31)

If applicable, enter the Medicare co-insurance amount for the specific procedure.

## MEDICARE DEDUCTIBLE (Field 31A)

If applicable, enter the Medicare deductible amount for the specific procedure.

## MEDICARE CO-PAY (Field 31B)

If applicable, enter the Medicare co-pay amount for the specific procedure.

## MEDICARE PAID (Field 31C)

If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denies payment, enter 0.00.

## OTHER INSURANCE PAID (Field 32)

This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage.

**Note**: **It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.**

If applicable, enter the amount actually paid by the other insurance carrier in this field.

If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient's billing record. Zeroes must also be entered in this field if any of the following situations apply:

- Prior to billing the insurance company, the provider knows that the service will not be covered because:
  - ► The provider has had a previous denial for payment for the service from the particular insurance policy. However, the provider should be aware that the service should be billed if the insurance policy changes. Proof of denials must be maintained in the patient's billing record. Prior claims denied due to deductibles not being met are not to be counted as denials for subsequent billings.

- ► In very limited situations, the Local Department of Social Services (LDSS) has advised providers to zero-fill other insurance payment for same type of service. This communication should be documented in the patient's billing record.

- The provider bills the insurance company and receives a rejection because:
  - ► The service is not covered; or
  - ► The deductible has not been met.

- The provider cannot directly bill the insurance carrier and the policyholder is either unavailable to or uncooperative in submitting claims to the insurance company. In these cases, the LDSS must be notified prior to zero-filling. LDSS has subrogation rights enabling it to complete claim forms on behalf of uncooperative policyholders who do not pay the provider for the services. The LDSS office can direct the insurance company to pay the provider directly for the service whether or not the provider participates with the insurance plan. The provider should contact the third-party worker in the local social services office whenever he/she encounters policyholders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases, the provider will be instructed to zero-fill the Other Insurance Payment in the Medicaid claim and the LDSS will retroactively pursue the third-party resource.

- The recipient or an absent parent collects the insurance benefits and fails to submit payment to the provider. The LDSS must be notified so that sanctions and/or legal action can be brought against the recipient or absent parent.

- The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

## Certification Section: Fields 37 through 38

### SIGNATURE (Field 37)

The provider or an authorized representative of the transportation firm must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

### COUNTY (Field 37A)

Enter the name of the county wherein the claim form is signed. The county may be left blank **only** when the provider's address, entered in Field 1, is within the county wherein the claim form is signed.

## DATE (Field 38)

Enter the date on which the provider or an authorized representative of the transportation provider signed the claim form. The date should be in the format MM/DD/YY.

**Note: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section on the web page for this manual.**

# Section III – Remittance Advice

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Advice.

eMedNY produces remittance advices on a weekly (processing cycle) basis. Weekly remittance advices contain the following information:

- A listing of all **claims** (identified by several pieces of information as submitted on the claim) that have entered the computerized processing system during the corresponding cycle.
- The **status** of each claim (deny/paid/pend) after processing.
- The eMedNY **edits** (errors) failed by pending or denied claims.
- **Subtotals** (by category, status, and member ID) and **grand totals** of claims and dollar amounts.
- Other **financial information** such as recoupments, negative balances, etc.

The remittance advice, in addition to showing a record of claim transactions, can assist providers in identifying and correcting billing errors and plays an important role in the communication between the provider and the eMedNY Contractor for resolving billing or processing issues.

Remittance advices are available in electronic and paper formats.

## Electronic Remittance Advice

The electronic HIPAA 835 transaction (Remittance Advice) is available via the eMedNY eXchange or FTP. To request the electronic remittance advice (835), providers must complete the Electronic Remittance Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

For additional information, providers may also call the eMedNY Call Center at 800-343-9000.

The NYS Medicaid Companion Guides for the 835 transaction are available at www.emedny.org by clicking on the link to the web page below:

**eMedNY Companion Guides and Sample Files**

Providers with multiple ETINs who choose to receive the 835 electronic remittance advice may elect to receive the status of paper claim submissions and state-submitted adjustments/voids in the 835 format. The request must be submitted using the Electronic Remittance Request Form located at www.emedny.org. If this option is chosen, no paper remittance will be produced and the status of claims will appear on the electronic 835 remittance advice for the ETIN indicated on the request form. Retro-adjustment information is also sent in the 835 transaction format. Pending claims do not appear in the 835 transaction; they are listed in the Supplemental file, which will be sent along with the 835 transaction for any processing cycle that produces pends.

**Note: Providers with only one ETIN who elect to receive an electronic remittance will have the status of any claims submitted via paper forms and state-submitted adjustments/voids reported on that electronic remittance.**

# Paper Remittance Advice

Remittance advices are also available on paper. Providers who bill electronically but do not specifically request to receive the 835 transaction are sent paper remittance advices.

## Remittance Sorts

The default sort for the paper remittance advice is:
Claim Status (denied, paid, pending) – Patient ID – TCN

Providers can request other sort patterns that may better suit their accounting systems. The additional sorts available are as follows:

- TCN – Claim Status – Patient ID – Date of Service
- Patient ID – Claim Status – TCN
- Date of Service – Claim Status – Patient ID

To request a sort pattern other than the default, providers must complete the Paper Remittance Sort Request Form, which is available at www.emedny.org by clicking on the link to the web page below:

**Provider Enrollment Forms**

For additional information, providers may call the eMedNY Call Center at 800-343-9000.

## Remittance Advice Format

The remittance advice is composed of five sections as described below.

- Section One may be one of the following:
  - ► Medicaid Check
  - ► Notice of Electronic Funds Transfer (EFT)
  - ► Summout (no claims paid)
- Section Two: Provider Notification (special messages)
- Section Three: Claim Detail
- Section Four:
  - ► Financial Transactions (recoupments)
  - ► Accounts Receivable (cumulative financial information)
- Section Five: Edit (Error) Description

## Explanation of Remittance Advice Sections

The next pages present a sample of each section of the remittance advice for Transportation services followed by an explanation of the elements contained in the section.

The information displayed in the remittance advice samples is for illustration purposes only.

The following information applies to a remittance advice with the default sort pattern.

## Section One – Medicaid Check

For providers who have selected to be paid by check, a Medicaid check is issued when the provider has claims approved for the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section contains the check stub and the actual Medicaid check (payment).

MEDICAID MANAGEMENT INFORMATION SYSTEM

TO: ABC TRANSPORTATION

DATE: 2007-08-06
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

07080600006 2007-08-06
ABC TRANSPORTATION
100 BROADWAY
ANYTOWN NY 11111

YOUR CHECK IS BELOW – TO DETACH, TEAR ALONG PERFORATED DASHED LINE

29
2

| DATE | REMITTANCE NUMBER | PROVIDER ID/NPI |
|---|---|---|
| 2007-08-06<br>VOID AFTER 90 DAYS | 07080600006 | 00112233/0123456789 |

PAY

| DOLLARS/CENTS |
|---|
| $*****143.80 |

TO THE ORDER OF

07080600006 2007-08-06
ABC TRANSPORTATION
100 BROADWAY
ANYTOWN NY 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

John Smith
AUTHORIZED SIGNATURE

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
CHECKS DRAWN ON
KEY BANK N.A.
60 STATE STREET, ALBANY, NEW YORK 12207

***Check Stub Information***

**UPPER LEFT CORNER**
Provider's name (as recorded in the Medicaid files)

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

**CENTER**
Remittance number/date
Provider's name/address

***Medicaid Check***

**LEFT SIDE**
Table
Date on which the check was issued
Remittance number
* Provider ID/NPI

Remittance number/date
Provider's name/address

**RIGHT SIDE**
Dollar amount. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

*** Note: NPI has been included on all examples and is pending NPI implementation by NYS Medicaid.**

## Section One – EFT Notification

For providers who have selected electronic funds transfer (or direct deposit), an EFT transaction is processed when the provider has claims approved during the cycle and the approved amount is greater than the recoupments, if any, scheduled for the cycle. This section indicates the amount of the EFT.

TO: ABC TRANSPORTATION


DATE: 2007-08-06
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456879

07080600006 2007-08-06
ABC TRANSPORTATION
100 BROADWAY
ANYTOWN NY 11111

ABC TRANSPORTATION $143.80

PAYMENT IN THE ABOVE AMOUNT WILL BE DEPOSITED VIA AN ELECTRONIC FUNDS TRANSFER.

***Information on the EFT Notification Page***

**UPPER LEFT CORNER**
Provider's name (as recorded in the Medicaid files)

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

**CENTER**
Remittance number/date
Provider's name/address

Provider's Name – Amount transferred to the provider's account. This amount must equal the Net Total Paid Amount under the Grand Total subsection plus the total sum of the Financial Transaction section.

## Section One – Summout (No Payment)

A summout is produced when the provider has no positive total payment for the cycle and, therefore, there is no disbursement of moneys.

TO: ABC TRANSPORTATION


DATE: 08/06/2007
REMITTANCE NO: 07080600006
PROVIDER ID/NPI: 00112233/0123456789

NO PAYMENT WILL BE RECEIVED THIS CYCLE. SEE REMITTANCE FOR DETAILS.

ABC TRANSPORTATION
100 BROADWAY
ANYTOWN NY 11111

***Information on the Summout Page***

**UPPER LEFT CORNER**
Provider Name (as recorded in Medicaid files)

**UPPER RIGHT CORNER**
Date on which the remittance advice was issued
Remittance number
* Provider ID/NPI

**CENTER**
Notification that no payment was made for the cycle (no claims were approved)
Provider name and address

## Section Two – Provider Notification

This section is used to communicate important messages to providers.

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 01
DATE 08/06/07
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
PROVIDER NOTIFICATION
PROVIDER ID/NPI 00112233/0123456789
REMITTANCE NO. 07080600006

REMITTANCE ADVICE MESSAGE TEXT

*** ELECTRONIC FUNDS TRANSFER (EFT) FOR PROVIDER PAYMENTS IS NOW AVAILABLE ***

PROVIDERS WHO ENROLL IN EFT WILL HAVE THEIR MEDICAID PAYMENTS DIRECTLY DEPOSITED INTO THEIR CHECKING OR SAVINGS ACCOUNT.

THE EFT TRANSACTIONS WILL BE INITIATED ON WEDNESDAYS AND DUE TO NORMAL BANKING PROCEDURES, THE TRANSFERRED FUNDS MAY NOT BECOME AVAILABLE IN THE PROVIDER'S CHOSEN ACCOUNT FOR UP TO 48 HOURS AFTER TRANSFER. PLEASE CONTACT YOUR BANKING INSTITUTION REGARDING THE AVAILABILITY OF FUNDS.

PLEASE NOTE THAT EFT DOES NOT WAIVE THE TWO-WEEK LAG FOR MEDICAID DISBURSEMENTS.

TO ENROLL IN EFT, PROVIDERS MUST COMPLETE AN EFT ENROLLMENT FORM THAT CAN BE FOUND AT WWW.EMEDNY.ORG. CLICK ON PROVIDER ENROLLMENT FORMS WHICH CAN BE FOUND IN THE FEATURED LINKS SECTION. DETAILED INSTRUCTIONS WILL ALSO BE FOUND THERE.

AFTER SENDING THE EFT ENROLLMENT FORM TO CSC, PLEASE ALLOW A MINIMUM TIME OF SIX TO EIGHT WEEKS FOR PROCESSING. DURING THIS PERIOD OF TIME YOU SHOULD REVIEW YOUR BANK STATEMENTS AND LOOK FOR AN EFT TRANSACTION IN THE AMOUNT OF $0.01 WHICH CSC WILL SUBMIT AS A TEST. YOUR FIRST REAL EFT TRANSACTION WILL TAKE PLACE APPROXIMATELY FOUR TO FIVE WEEKS LATER.

IF YOU HAVE ANY QUESTIONS ABOUT THE EFT PROCESS, PLEASE CALL THE EMEDNY CALL CENTER AT 1-800-343-9000.

***Information on the Provider Notification Page***

**UPPER LEFT CORNER**
Provider's name and address

**UPPER RIGHT CORNER**
Remittance page number
Date on which the remittance advice was issued
Cycle number

ETIN (not applicable)
Name of section: **PROVIDER NOTIFICATION**
* Provider ID/NPI
Remittance number

**CENTER**
Message text

## Section Three – Claim Detail

This section provides a listing of all new claims that were processed during the specific cycle plus claims that were previously pended and adjudicated (paid or denied) during the specific cycle. This section may also contain pending claims from previous cycles that still remain in a pend status.

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 02
DATE 08/06/2007
CYCLE 1563

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP343444 | DAVIS | UU44444R | 07206-000000227-0-0 | 07/11/07 | NY211 | 48.000 | 52.80 | 0.00 | DENY | 00162 00244 |
| 01 | CP443544 | BROWN | PP88888M | 07206-000011334-0-0 | 07/11/07 | NY211 | 16.000 | 17.60 | 0.00 | DENY | 00244 |
| 01 | CP766578 | MALONE | SS99999L | 07206-000013556-0-0 | 07/19/07 | NY211 | 13.000 | 14.30 | 0.00 | DENY | 00162 |
| 01 | CP999890 | SMITH | ZZ22222T | 07206-000032456-0-0 | 07/20/07 | NY211 | 63.000 | 77.50 | 0.00 | DENY | 00131 |

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

| | | | | |
|---|---|---|---|---|
| TOTAL AMOUNT ORIGINAL CLAIMS | DENIED | 162.20 | NUMBER OF CLAIMS | 4 |
| NET AMOUNT ADJUSTMENTS | DENIED | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS | DENIED | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS – ADJUSTS | | 0.00 | NUMBER OF CLAIMS | 0 |

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 03
DATE 08/06/2007
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP112346 | DAVIS | UU44444R | 07206-000033667-0-0 | 07/11/07 | NY211 | 13.000 | 14.30 | 14.30 | PAID | |
| 02 | CP112345 | DAVIS | UU44444R | 07206-000033667-0-0 | 07/12/07 | NY211 | 13.000 | 14.30 | 14.30 | PAID | |
| 01 | CP113433 | CRUZ | LL11111B | 07206-000045667-0-0 | 07/14/07 | NY211 | 48.000 | 52.80 | 52.80 | PAID | |
| 01 | CP445677 | JONES | YY33333S | 07206-000056767-0-0 | 07/15/07 | NY211 | 66.000 | 66.00 | 66.00 | PAID | |
| 01 | CP113487 | WAGER | ZZ98765R | 07206-000067767-0-0 | 06/05/07 | NY211 | 17.000 | 17.60 | 17.60- | ADJT | ORIGINAL CLAIM PAID 06/24/07 |
| 01 | CP744495 | PARKER | VZ45678P | 07206-000088767-0-0 | 06/05/07 | NY211 | 13.000 | 14.30 | 14.00 | ADJT | |

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

| | | | | |
|---|---|---|---|---|
| TOTAL AMOUNT ORIGINAL CLAIMS | PAID | 147.40 | NUMBER OF CLAIMS | 4 |
| NET AMOUNT ADJUSTMENTS | PAID | 3.60- | NUMBER OF CLAIMS | 1 |
| NET AMOUNT VOIDS | PAID | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS – ADJUSTS | | 3.60- | NUMBER OF CLAIMS | 1 |

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE 04
DATE 08/06/2007
CYCLE 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

| LN. NO | OFFICE ACCOUNT NUMBER | CLIENT NAME | CLIENT ID NUMBER | TCN | DATE OF SERVICE | PROC. CODE | UNITS | CHARGED | PAID | STATUS | ERRORS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | CP8765432 | CRUZ | LL11111B | 07206-000033467-0-0 | 07/13/07 | NY211 | 60.000 | 69.30 | 0.00 | **PEND | 00162 |
| 02 | CP4555557 | CRUZ | LL11111B | 07206-000033468-0-0 | 07/14/07 | NY211 | 63.000 | 71.04 | 0.00 | **PEND | 00162 |
| 01 | CP8876543 | TAYLOR | GG43210D | 07206-000035665-0-0 | 07/14/07 | NY211 | 13.000 | 14.30 | 0.00 | **PEND | 00142 |
| 01 | CP0009765 | ESPOSITO | FF98765C | 07206-000033660-0-0 | 07/12/07 | NY211 | 13.000 | 14.30 | 0.00 | **PEND | 00131 |

* = PREVIOUSLY PENDED CLAIM
** = NEW PEND

| | | | | |
|---|---|---|---|---|
| TOTAL AMOUNT ORIGINAL CLAIMS | PEND | 168.94 | NUMBER OF CLAIMS | 4 |
| NET AMOUNT ADJUSTMENTS | PEND | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS | PEND | 0.00 | NUMBER OF CLAIMS | 0 |
| NET AMOUNT VOIDS – ADJUSTS | | 0.00 | NUMBER OF CLAIMS | 0 |

REMITTANCE TOTALS – TRANSPORTATION

| | | | |
|---|---|---|---|
| VOIDS – ADJUSTS | 3.60- | NUMBER OF CLAIMS | 1 |
| TOTAL PENDS | 168.94 | NUMBER OF CLAIMS | 4 |
| TOTAL PAID | 147.40 | NUMBER OF CLAIMS | 4 |
| TOTAL DENIED | 162.20 | NUMBER OF CLAIMS | 4 |
| NET TOTAL PAID | 143.80 | NUMBER OF CLAIMS | 5 |

MEMBER ID: 00112233

| | | | |
|---|---|---|---|
| VOIDS – ADJUSTS | 3.60- | NUMBER OF CLAIMS | 1 |
| TOTAL PENDS | 168.94 | NUMBER OF CLAIMS | 4 |
| TOTAL PAID | 147.40 | NUMBER OF CLAIMS | 4 |
| TOTAL DENIED | 162.20 | NUMBER OF CLAIMS | 4 |
| NET TOTAL PAID | 143.80 | NUMBER OF CLAIMS | 5 |


PAGE: 05
DATE: 08/06/07
CYCLE: 1563

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
GRAND TOTALS
PROVIDER ID/NPI: 00112233/0213456789
REMITTANCE NO: 07080600006

REMITTANCE TOTALS – GRAND TOTALS

| | | | |
|---|---|---|---|
| VOIDS – ADJUSTS | 3.60- | NUMBER OF CLAIMS | 1 |
| TOTAL PENDS | 168.94 | NUMBER OF CLAIMS | 4 |
| TOTAL PAID | 147.40 | NUMBER OF CLAIMS | 4 |
| TOTAL DENY | 162.20 | NUMBER OF CLAIMS | 4 |
| NET TOTAL PAID | 143.80 | NUMBER OF CLAIMS | 5 |

### *General Information on the Claim Detail Pages*

**UPPER LEFT CORNER**
Provider's name and address

**UPPER RIGHT CORNER**
Remittance page number
Date on which the remittance advice was issued
Cycle number. The cycle number should be used when calling the eMedNY Call Center with questions about specific processed claims or payments.

ETIN (not applicable)
Provider Service Classification: **TRANSPORTATION**
* Provider ID/NPI
Remittance number

### *Explanation of the Claim Detail Columns*

**LN. NO. (LINE NUMBER)**
This column indicates the line number of each claim as it appears on the claim form.

**OFFICE ACCOUNT NUMBER**
If a Patient/Office Account Number was entered in the claim form, that number (up to 20 characters) will appear under this column.

**CLIENT NAME**
This column indicates the last name of the patient. If an invalid Medicaid Client ID was entered in the claim form, the ID will be listed as it was submitted but no name will appear under this column.

**CLIENT ID NUMBER**
The client's Medicaid ID number appears under this column.

**TCN**
The TCN is a unique identifier assigned to each document (claim form) that is processed. If multiple claim lines are submitted on the same claim form, all the lines are assigned the same TCN.

**DATE OF SERVICE**
This column lists the service date as entered in the claim form.

**PROCEDURE CODE**
The five-digit procedure code that was entered in the claim form appears under this column.

**UNITS**
The total number of units of service for the specific claim appears under this column. The units are indicated with three (3) decimal positions. Since Transportation providers must only report whole units of service, the decimal positions will always be 000. For example: 3 units will be indicated as 3.000.

**CHARGED**
This column lists either the amount the provider charged for the claim or the Medicare Approved amount if applicable.

**PAID**
If the claim is approved, the amount paid appears under this column. If the claim has a pend or deny status, the amount paid will be zero (0.00).

**STATUS**
This column indicates the status (DENY, PAID/ADJT/VOID, PEND) of the claim line.

**Denied Claims**
Claims for which payment is denied will be identified by the **DENY** status. A claim may be denied for the following general reasons:

- The service rendered is not covered by the New York State Medicaid Program.
- The claim is a duplicate of a prior paid claim.
- The required Prior Approval has not been obtained.
- Information entered in the claim form is invalid or logically inconsistent.

**Approved Claims**
Approved claims will be identified by the statuses **PAID, ADJT** (adjustment), or **VOID**.

***Paid Claims***
The status **PAID** refers to **original** claims that have been approved.

***Adjustments***
The status **ADJT** refers to a claim submitted in replacement of a paid claim with the purpose of changing one or more fields. An adjustment has two components: the credit transaction (previously paid claim) and the debit transaction (adjusted claim).

***Voids***
The status **VOID** refers to a claim submitted with the purpose of canceling a previously paid claim. A void lists the credit transaction (previously paid claim) only.

**Pending Claims**
Claims that require further review or recycling will be identified by the **PEND** status. The following are examples of circumstances that commonly cause claims to be pended:

- New York State Medical Review required.
- Procedure requires manual pricing.
- No match found in the Medicaid files for certain information submitted on the claim, for example: Client ID, Prior Approval, Service Authorization. These claims are recycled for a period of time during which the Medicaid files may be updated to match the information on the claim.

After manual review is completed, a match is found in the Medicaid files, or the recycling time expires, pended claims may be approved for payment or denied.

A new pend is signified by two asterisks (**). A previously pended claim is signified by one asterisk (*).

**ERRORS**
For claims with a DENY or PEND status, this column indicates the NYS Medicaid edit (error) numeric code(s) that caused the claim to deny or pend. Some edit codes may also be indicated for a PAID claim. These are “approved” edits, which identify certain “errors” found in the claim, which do not prevent the claim from being approved. Up to twenty-five (25) edit codes, including approved edits, may be listed for each claim. Edit code definitions will be listed on the last page(s) of the remittance advice.

***Subtotals/Totals***
Subtotals of dollar amounts and number of claims are provided as follows:

Subtotals by **claim status** appear at the end of the claim listing for each status. The subtotals are broken down by:

- Original claims
- Adjustments
- Voids
- Adjustments/voids combined

Subtotals by **provider type** are provided at the end of the claim detail listing. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Denied
- Net total paid (sum of approved adjustments/voids and paid original claims)

Totals by **member ID** are provided next to the subtotals for provider type. For individual practitioners, these totals are exactly the same as the subtotals by provider type. For practitioner groups, this subtotal category refers to the specific member of the group who provided the services. These subtotals are broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (sum of approved adjustments/voids and paid original claims)

**Grand Totals** for the entire provider remittance advice appear on a separate page following the page containing the **totals** by **provider type and member ID**. The grand total is broken down by:

- Adjustments/voids (combined)
- Pends
- Paid
- Deny
- Net total paid (entire remittance)

## Section Four

This section has two subsections:

- Financial Transactions
- Accounts Receivable

### *Financial Transactions*

The Financial Transactions subsection lists all the recoupments that were applied to the provider during the specific cycle. If there is no recoupment activity, this subsection is not produced.

MEDICAID MANAGEMENT INFORMATION SYSTEM

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DATE 08/06/07
CYCLE 1563

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

ETIN:
FINANCIAL TRANSACTIONS
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

| FCN | FINANCIAL REASON CODE | FISCAL TRANS TYPE | DATE | AMOUNT |
|---|---|---|---|---|
| 200705060236547 | XXX | RECOUPMENT REASON DESCRIPTION | 05 09 07 | $$.$$ |

NET FINANCIAL AMOUNT $$$.$$ NUMBER OF FINANCIAL TRANSACTIONS XXX

### *Explanation of the Financial Transactions Columns*

**FCN (FINANCIAL CONTROL NUMBER)**
This is a unique identifier assigned to each financial transaction.

**FINANCIAL REASON CODE**
This code is for DOH/CSC use only; it has no relevance to providers. It identifies the reason for the recoupment.

**FISCAL TRANSACTION TYPE**
This is the description of the Financial Reason Code. For example: Third Party Recovery.

**DATE**
The date on which the recoupment was applied. Since all the recoupments listed on this page pertain to the current cycle, all the recoupments will have the same date.

**AMOUNT**
The dollar amount corresponding to the particular fiscal transaction. This amount is deducted from the provider's total payment for the cycle.

### *Totals*

The total dollar amount of the financial transactions (**Net Financial Transaction Amount**) and the total number of transactions (**Number of Financial Transactions**) appear below the last line of the transaction detail list.

The Net Financial Transaction Amount added to the Claim Detail-Grand Total must equal the Medicaid Check or EFT amounts.

### *Accounts Receivable*

This subsection displays the original amount of each of the outstanding Financial Transactions and their current balance after the cycle recoupments were applied. If there are no outstanding negative balances, this section is not produced.

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DATE 08/06/07
CYCLE 1563

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

ETIN:
ACCOUNTS RECEIVABLE
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

| REASON CODE DESCRIPTION | ORIG BAL | CURR BAL | RECOUP %/AMT |
|---|---|---|---|
| | $XXX.XX- | $XXX.XX- | 999 |
| | $XXX.XX- | $XXX.XX- | 999 |

TOTAL AMOUNT DUE THE STATE $XXX.XX

### *Explanation of the Accounts Receivable Columns*

If a provider has negative balances of different types or negative balances created at different times, each negative balance will be listed in a different line.

**REASON CODE DESCRIPTION**
This is the description of the Financial Reason Code. For example: Third Party Recovery.

**ORIGINAL BALANCE**
The original amount (or starting balance) for any particular financial reason.

**CURRENT BALANCE**
The current amount owed to Medicaid (after the cycle recoupments, if any, were applied). This balance may be equal to or less than the original balance.

**RECOUPMENT % AMOUNT**
The deduction (recoupment) scheduled for each cycle.

### *Total Amount Due the State*

This amount is the sum of all the **Current Balances** listed above.

## Section Five – Edit Descriptions

The last section of the Remittance Advice features the description of each of the edit codes (including approved codes) failed by the claims listed in Section Three.

MEDICAID MANAGEMENT INFORMATION SYSTEM

**MEDICAL ASSISTANCE (TITLE XIX) PROGRAM**
**REMITTANCE STATEMENT**

PAGE 06
DATE 08/06/07
CYCLE 1563

TO: ABC TRANSPORTATION
100 BROADWAY
ANYTOWN, NEW YORK 11111

ETIN:
TRANSPORTATION
EDIT DESCRIPTIONS
PROVIDER ID/NPI: 00112233/0123456789
REMITTANCE NO: 07080600006

THE FOLLOWING IS A DESCRIPTION OF THE EDIT REASON CODES THAT APPEAR ON THE CLAIMS FOR THIS REMITTANCE:

| | |
|---|---|
| 00131 | PROVIDER NOT APPROVED FOR SERVICE |
| 00142 | SERVICE CODE NOT EQUAL TO PA |
| 00162 | RECIPIENT INELIGIBLE ON DATE OF SERVICE |
| 00244 | PA NOT ON OR REMOVED FROM FILE |

# Appendix A – Code Sets

## Accident Codes

| Code | Description |
|---|---|
| 0/Blank | Not Applicable |
| 1 | Auto Accident |
| 2 | Employment |
| 3 | Another Party Responsible |
| 4 | Other Accident |

## United States Standard Postal Abbreviations

| State | Abbrev. | State | Abbrev. |
|---|---|---|---|
| Alabama | AL | Missouri | MO |
| Alaska | AK | Montana | MT |
| Arizona | AZ | Nebraska | NE |
| Arkansas | AR | Nevada | NV |
| California | CA | New Hampshire | NH |
| Colorado | CO | New Jersey | NJ |
| Connecticut | CT | New Mexico | NM |
| Delaware | DE | North Carolina | NC |
| District of Columbia | DC | North Dakota | ND |
| Florida | FL | Ohio | OH |
| Georgia | GA | Oklahoma | OK |
| Hawaii | HI | Oregon | OR |
| Idaho | ID | Pennsylvania | PA |
| Illinois | IL | Rhode Island | RI |
| Indiana | IN | South Carolina | SC |
| Iowa | IA | South Dakota | SD |
| Kansas | KS | Tennessee | TN |
| Kentucky | KY | Texas | TX |
| Louisiana | LA | Utah | UT |
| Maine | ME | Vermont | VT |
| Maryland | MD | Virginia | VA |
| Massachusetts | MA | Washington | WA |
| Michigan | MI | West Virginia | WV |
| Minnesota | MN | Wisconsin | WI |

| American Territories | Abbrev. |
|---|---|
| American Samoa | AS |
| Canal Zone | CZ |
| Guam | GU |
| Puerto Rico | PR |
| Trust Territories | TT |
| Virgin Islands | VI |

**Note: Required only when reporting out-of-state license numbers.**

# NEW YORK STATE

# MEDICAID TRANSPORTATION

# CITY OF NEW YORK

# TRANSPORTATION ORDERING GUIDELINES MANUAL

# Table of Contents

# Introduction

When the Medicaid Program was established in the 1960s, lawmakers said that:

> *"The aid, care and support of the needy are public concerns…"*
> *NYS Constitution – Article XVII – Section 1*

By the very nature of the Medicaid population, getting to and from services can be a struggle. If the enrollee can not get to services, then the Program fails from the start; so New York State made the decision to cover a series of optional services under the Medicaid Program, including medical transportation.

In order to maintain enough flexibility to sufficiently meet the needs of Medicaid enrollees in a significantly culturally and geographically diverse State, the responsibility of managing the New York State Medicaid Transportation Program was delegated to each county's local departments of social services.

> The New York City Medicaid Transportation Program is administered by the City of New York Human Resources Administration, which encompasses the five boroughs of the City of New York, with oversight by the New York State Department of Health.

This Manual will clarify the rules of ordering, required forms, and other important information needed for the ordering of fee-for-service medical transportation of **New York City** Medicaid enrollees.

> There may be an occasion where a practitioner in the City of New York will need to arrange for the transportation of a Medicaid enrollee whose county of fiscal responsibility is not the City of New York. For these enrollees, the practitioner must contact the local department of social services in the county who retains eligibility for the enrollee. Contact telephone numbers of counties surrounding the City of New York are included in this Manual.

For questions, please contact the Medicaid Program's Transportation Unit:

| | |
|---|---|
| Telephone: | (518) 474-5187 |
| Fax: | (518) 473-5884 |
| Email: | medtrans@health.state.ny.us |

# Section I – Covered Transportation Services

Medicaid covers the transportation of eligible, enrolled persons who need transportation to and from Medicaid-covered services.

When traveling to medical appointments, a Medicaid enrollee is to use the same mode of transportation as used to carry out the duties of daily life. For most New York City residents, this mode is bus or subway; however, for some Medicaid enrollees, their condition necessitates another form of transport, such as an ambulette.

> In these circumstances, Medicaid will pay for the **least costly, most medically appropriate** level of transportation to and from services covered by the Medicaid Program.

Covered transportation services include:

- Public transportation;
- Livery;
- Ambulette; and
- Non-emergency ambulance.

# Section II – Rules for Ordering

As an ordering practitioner, you are responsible for ordering only necessary transportation within the common medical marketing area (CMMA).

> *The CMMA is the geographic area from which a community customarily obtains its medical care and services. In New York City, the CMMA is five miles from one's residence.*

Enrollees who have reasonable access to a mode of transportation used for the normal activities of daily living; such as shopping and recreational events; are expected to use this mode to travel to and from medical appointments when that mode is available to them. For most residents of New York City, this mode is usually mass transit.

Medicaid may restrict payment for transportation if it is determined that:

- the enrollee chose to go to a medical provider outside the CMMA when services were available within the CMMA;
- the enrollee could have taken a less expensive form of transportation but opted to take the more costly transportation.

In either case above, if the enrollee can demonstrate circumstances justifying payment, then reimbursement can be *considered*.

## Responsibility of the Ordering Practitioner

As the medical practitioner requesting livery, ambulette, or non-emergency ambulance services, you are also responsible for ordering the *medically appropriate* mode of transportation for the Medicaid enrollee.

> A basic consideration for this should be the enrollee's current level of mobility and functional independence.

The transportation ordered should be the least specialized mode required based upon the enrollee's *current* medical condition. For example, if you feel the enrollee does not require personal assistance, but cannot walk to public transportation, you should authorize livery service, not ambulette service.

**Any order practitioner or facilities/programs ordering on the practitioner's behalf, which do not meet the rules of this section, may be sanctioned according to the regulations established by the Department of Health at Title 18 Section 515.3, available online at:**

http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

## Ordering Transportation for Non-New York City Enrollees

When a practitioner needs to arrange transportation for a Medicaid enrollee whose Medicaid eligibility is not 66-NYC, then the guidelines in this Manual ***do not apply***. Rather, the practitioner must contact the local department of social services in the county who establishes eligibility for the enrollee (i.e., 28-Nassau; 55-Westchester) in order to request a prior authorization for transportation services.

Transportation contact information for those counties surrounding the City of New York is below:

| County | Transportation Contact Telephone Number |
|---|---|
| 28-Nassau | (516) 433-4603 |
| 39-Rockland | (845) 364-3052 |
| 47-Suffolk | (631) 854-5801 |
| 55-Westchester | (914) 813-5642 |

## Non-emergency Ambulance

Generally, ambulance service is requested when a Medicaid enrollee needs to be transported in a recumbent position or is in need of medical attention while en route to their medical appointments.

A request for prior authorization must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant; or
- Nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation on behalf of the ordering practitioner.

## Ambulette

Ambulette service is door-to-door; from the enrollee's home through the door of the medical appointment. Personal assistance by the staff of the ambulette company is

required by the Medicaid Program in order to bill the Program for the provision of ambulette service.

**If personal assistance is not necessary and/or not provided, then livery service should be ordered.**

Ambulettes may also provide taxi (curb-to-curb) service and will transport livery-eligible enrollees in the same vehicle as ambulette-eligible enrollees. The Medicaid Program does not require the ambulette service to be licensed as a taxi service; the only requirement that ambulettes need to meet for this service is the proper authority and license to operate as an ambulette.

A request for prior authorization of ambulette transportation must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist; or
- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The Medicaid enrollee needs to be transported in a recumbent position and the ambulette service is able to accommodate a stretcher;
- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery service, bus or private vehicle;
- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle;

- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments which result in a disabling physical condition after treatment, making the enrollee unable to access transportation without personal assistance provided by an ambulette service;

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette services; and,

- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, livery service, bus or private vehicle and there is a need for ambulette service.

**The ordering practitioner must note in the patient's record the condition which qualifies the use of ambulette services.**

## Livery Transportation

A request for prior authorization for transportation by New York City livery services must be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;

- Physician's assistant;

- Nurse practitioner;

- Dentist;

- Optometrist;

- Podiatrist; or

- Other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

## Day Treatment Transportation

Day treatment/day program transportation is unique in that this transportation can be provided by an ambulance, ambulette or livery provider. The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

Providers of transportation to day treatment/day program must adhere to the same requirements for their specific provider category.

## Mileage

Mileage within urban areas is difficult to control; therefore, New York City has established fixed reimbursement amounts for trips occurring within the five boroughs encompassing the City for **all modes of transportation**.

When a trip occurs within **any** of the five boroughs, i.e., Queens to Manhattan, mileage should **not** be ordered.

When a New York City Medicaid enrollee requires long-distance transportation, i.e., Manhattan to Suffolk County, mileage may be ordered, **beginning at the City limits**.

# Section III – Required Documentation

In cases where an ordering practitioner believes that a Medicaid enrollee should use a particular form of non-emergency transportation, Medicaid guidelines at Title 18 of the New York Code of Rules and Regulations Section 505.10 (c)(4) indicate that:

> *"The ordering practitioner must note in the [enrollee's] patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services."*

## The MAP-2015

### What is the MAP-2015?

The MAP-2015, included on the following pages, is the identifier created by the Medicaid Program in the City of New York to be used as a concise justification for the ordering of livery, ambulette and non-emergency ambulance transportation services for Medicaid enrollees in the City of New York.

> *The MAP-2015 is **not** a request for transportation prior authorization. Rather, this form is used **in conjunction** with a request for Medicaid transportation prior authorization to **support** the order for a particular mode of transportation.*

### Why use the MAP-2015?

When traveling to medical appointments, a Medicaid enrollee is to use the same mode of transportation as used to carry out the duties of daily living. For most New York City residents, this mode is bus or subway. However, for some enrollees, their condition necessitates another form of transport, such as an ambulette. In these circumstances, Medicaid will pay for the most **medically appropriate** level of transportation to and from services covered by the Medicaid Program.

In cases where an ordering practitioner believes that a Medicaid enrollee should use a particular form of non-emergency transportation, Medicaid guidelines at Title 18 of the New York Code of Rules and Regulations Section 505.10(c)(4) indicate that:

> *"The ordering practitioner must note in the [enrollee's] patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services."*

### Who should complete the MAP-2015?

Those practitioners who order non-emergency transportation services on behalf of a City of New York Medicaid enrollee should complete the form.

### When should the MAP-2015 be used?

The MAP-2015 **should be** used when:

- a patient has a condition that necessitates a mode of transportation other than mass transit, but that necessity cannot be readily discerned from the patient's medical record.

The MAP-2015 is **not** necessary when:

- a patient can use mass transit; or
- it is clear from the patient's record that mass transit would be difficult to navigate, e.g., a wheelchair-bound double leg amputee.
- upon discharge from a hospital, the **Discharge Plan** clearly indicates the presence of a condition necessitating livery, ambulette or non-emergency ambulance transportation.

### How is the MAP-2015 completed?

The MAP-2015 requests patient-specific information such as the patient's name, address, Medicaid enrollee identification number, diagnoses, requested authorization time span and space to justify the need for higher level of transportation. Additionally, there are yes/no questions, such as whether or not the patient uses a wheelchair.

On the second page, there is a certification statement and places where those involved in the completion of the form identify themselves.

### Does a new MAP-2015 need to be completed for each trip requested?

No. An authorization can cover one trip or many trips during the authorization period. A six-month authorization period is available for patients with acute conditions, and a twelve-month authorization period is available for patients with chronic conditions.

The MAP-2015 should be updated as soon as possible if a patient's condition changes during the authorization period or upon expiration of the authorization period.

### Where is the completed MAP-2015 to be kept?

Once completed, the form should be maintained in the Medicaid enrollee's patient record.

### Inappropriate Orders

Recent transportation audits by the Office of the Medicaid Inspector General have revealed that ordering providers are not aware of the need to complete the MAP-2015, do not fill out the form completely and correctly, or fail to keep the form in the medical

records of the patients, as required. Transportation ordering providers are hereby reminded that:

1. They should comply with the instructions for completing MAP-2015; and

2. Title 18 of the Official Compilations of Rules and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) require providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services.

The Office of the Medicaid Inspector General audits the ordering practitioners of transportation services to ensure that they are in compliance with the appropriate regulations.

MAP-2015 (face)
Rev. 8/15/01

Human Resources Administration
Medical Assistance Programs

# LIVERY, AMBULETTE & NON-EMERGENCY AMBULANCE SERVICES MEDICAID TRANSPORTATION PRIOR APPROVAL FORM

Patient Name _____Date of Birth ____/_____/_____ Sex _____

Address _____

Medicaid ID.: _____ Social Security Number _____-_____-_____

1. (a) List Diagnoses (PRINT):
   1) _____ 2) _____
   3) _____ 4) _____
   5)_____ 6) _____

   (b) Why do these diagnoses justify transportation other than Public Transportation?

_____
_____
_____

2. (a) Does the patient use a wheelchair, scooter or portable oxygen? Yes ☐ No ☐

   (b) Does the patient require personal assistance of another individual to enter or exit a building or vehicle? Yes ☐ No ☐

   (c) Does the patient have a family member or home attendant traveling with him/her? Yes ☐ No ☐

3. (a) Is the patient's departure/destination point within his/her CMMA? (see definition under the Certification Statement) Yes ☐ No ☐

   (b) If not, justify travel outside CMMA

_____
_____
_____
_____

4. Respond to this question only if **Non-Emergency Ambulance** is requested.

   (a) Does the patient require life-sustaining equipment during transport? Yes ☐ No ☐

   (b) Does the patient require monitoring by a certified emergency medical technician or paramedic during transport? Yes ☐ No ☐

   (c) Does the patient need to be transported in a reclining position for:

   1) Medical reasons Yes ☐ No ☐ 2) Psychiatric condition Yes ☐ No ☐

   (d) Does the patient require use of the vehicle's oxygen during transport? Yes ☐ No ☐

5. Indicate the location and the mode of transportation ordered pursuant to the filing of this document. Consult the New York State Department of Health ordering guidelines for definition of each mode of travel.

   (a) Location: ☐ Travel is within the CMMA ☐ Travel is outside the CMMA.

   (b) Mode: ☐ LIVERY ☐ AMBULETTE ☐ Non-Emergency AMBULANCE

6. This transportation authorization is from ____/_____/_____ to ____/_____/_____.
   *(NOTE: An authorization may cover a one way trip; a six-month period for patients with acute conditions; or twelve months for patients with chronic conditions).*

MAP-2015 (reverse)
Rev. 8/15/01

Human Resources Administration
Medical Assistance Programs

**INSTRUCTIONS**
Updated form is required when authorization period expires or when change in patient's condition results in a higher level of transportation. Form must be retained in medical practitioner's place of business readily retrievable for audit purposes.

**CERTIFICATION STATEMENT**
I (or the entity) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

I (or the entity) understand that the Common Medical Market Area (CMMA), as defined by New York State Social Service Regulation 505.10(b)(5), means the geographic area from which a community customarily obtains its medical care and services. This area lies within a five-mile radius of the enrollee's residence.

HRA does not intend to limit an enrollee's freedom to choose any Medicaid practitioner in the New York City region. Enrollees are allowed to receive care and services from any practitioner willing to provide care. However, HRA is not required to pay the transportation expenses of an enrollee to accommodate one's free choice when the same medical service is available closer to one's residence. Internal medicine, general and family practice, OB/GYN, pediatric and psychiatric services are considered by HRA to be typically available to Medicaid enrollees/patients within the CMMA. This listing is not deemed all-inclusive.

By ordering transportation services for Medicaid enrollees/patients traveling outside the CMMA, I (or the entity) certify that the Medicaid enrollee/patient requires specialized care not available within the enrollee/patient's CMMA, or that failure to maintain the continuity of services with a particular medical provider, although other appropriate care is available to the enrollee/patient within the CMMA, is essential to the enrollee/patient's physical and mental health, or there is an imminent need to initiate ongoing medical services that may be available within the CMMA but for which there exists a waiting list to receive care.

| Practitioner's Name (PRINT) | Practitioner's Signature |
|---|---|
| Telephone Number | License Number |
| Hospital/Clinic/Inst. Name | Medical Practitioner's Address |
| MMIS ID # | Date |

Indicate name of Nurse/Social Worker/Other Person assisting in completing this Form.

| Name (PRINT) | Title |
|---|---|
| Telephone Number | |

# Section IV – Requesting Transportation Prior Authorization

First, Orderers must verify that the county of fiscal responsibility for the enrollee is the City of New York (66-NYC).

> **If the county of fiscal responsibility is not 66-NYC, then the orderer must contact the county of fiscal responsibility and follow their rules for ordering transportation.**

All efforts should be made to submit requests for prior authorizations before the first date of service. However, it is understood that sometimes unforeseen circumstances arise that delay the submission of the prior authorization request until after the service has been provided.

Orderers in New York City have two options for the ordering of Medicaid transportation of New York City Medicaid enrollees:

1. Call the eMedNY Call Center at (800) 343-9000 option 1, sub-option 3. Be prepared to provide the following information:

   - eMedNY identification number of the:
     - Medicaid enrollee,
     - ordering provider and
     - transportation provider;
   - first and last dates of transport;
   - procedure code; and
   - number of *round trips* requested.

2. Complete one of two forms:

   - eMedNY 389701 – Transportation Prior Approval; or
   - eMedNY 410601 – Group Transportation Prior Approval.

## Procedure Codes

Procedure codes are required in order to request transportation services. Procedure codes are the rate-specific codes given to a specific service rendered by a transportation provider.

The following procedure codes have been established for the most commonly requested forms of New York City transportation:

| Service | Procedure Code | Description |
|---|---|---|
| Ambulette | NY100 | Trip up to 5 miles |
| | NY102 | Trip greater than 5 miles |
| Livery | NY200 | Trip up to 5 miles |
| | NY202 | Trip greater than 5 miles |

## Completing the Paper Prior Approval Request Forms

It is *imperative* that the following procedures are used when completing the eMedNY-389701 and/or the eMedNY-410601 Transportation Prior Approval Request forms.

Please note that these forms may not have any white-out or cross-out markings, and are to be used **only** for New York City Medicaid Enrollees.

To reduce processing errors and subsequent delays, do not run over writing or typing from one field or box into another.

### eMedNY-389701 Field by Field Instructions

**Field 1 – Ordering Provider Number**
The eight-digit Medicaid provider identification number of the provider that is ordering the trip/s is entered in this field. This number will always be a Medicaid Provider Identification Number and not a license number. Right justify the information as shown in the example below.

Example:

ORDERING PROVIDER NUMBER

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Field 2 – Name and Address (Ordering Provider)**
Enter the name and address of the ordering provider in this field.

**Field 3 – Proc Code**
The appropriate procedure code is to be entered in the field.

**Field 4 – Transportation Provider Number**
The eight-digit Medicaid provider identification number of the transportation provider is to be entered in the field.

**Field 5 – Name and Address (Transportation Provider)**
Enter the transportation provider's name and address in the field.

**Field 6 – Enrollee ID**
The Medicaid enrollee's Medicaid identification number is entered in this field. If the number is invalid, a rejection will result and will appear on your weekly transportation ordering provider roster.

**Field 7 – Beginning Date of Service**
The first date of service for this prior authorization is to be entered in this field.

**Field 8 – No. of Units**
The total number of **one-way** trips is to be entered in this field. A round trip is indicated by entering 002.

**Field 9 – Cal Days [Calendar Days]**
The total number of calendar days to cover the entire period of the prior authorization is to be entered in this field.

**Field 10 – Appt Time [Appointment Time]**
This field indicates the time of appointment for the Medicaid enrollee. This field may be left blank by the ordering practitioner.

**Field 11 – Destination**
This field may be left blank by the ordering practitioner.

**Field 12 – Enrollee Name**
The enrollee's name is entered in this field, last name first.

**Field 13 – Address**
This field may be left blank by the ordering practitioner.

**Field 14 – For Official Use Only**
LEAVE THIS FIELD BLANK.

**Field 15 – Signature**
An authorized agent for the ordering practitioner **must** sign the form in this field.

**Field 16 – Date**
Enter the date the form was signed by the authorized agent of the ordering practitioner in this field.

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM
TRANSPORTATION PRIOR APPROVAL
1. ORDERING PROVIDER NUMBER
2. NAME ADDRESS
3. PROC CODE
5. TRANSPORTATION PROVIDER NUMBER
2. NAME ADDRESS
7. CLIENT ID
8. BEGINNING DATE OF SERVICE
9. NUMBER OF UNITS
10. CAL DAYS
11. APPT TIME
14. DESTINATION
17. ADDRESS
16. CLIENT NAME
18. FOR OFFICIAL USE ONLY
I certify that the above orders are for trips that are medically necessary at the level of transportation ordered. And that statements on the reverse side apply to this order and are made a part hereof.
19. SIGNATURE
20. DATE
M M D D C C Y Y
DO NOT STAPLE IN BARCODE AREA
Please ll Sample - Not for Submission
E MEDNY-389701 (04/04)

## CERTIFICATION

Orderer certifies that: I am (or the business entity named on this form is) a qualified orderer enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this transportation prior approval request; I have reviewed this form. I (or the entity) order or cause to be ordered the services itemized in accordance with applicable federal and state laws and regulations; ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT FOR THE ORDERED SERVICES WILL BE FROM FEDERAL, STATE, AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; all records pertaining to the ordering of these services including all records which are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and as such records and information regarding this ordered service shall be promptly furnished upon request to the local or State Department of Health, the State Medicaid Fraud Control Unit, or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex, and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to accept the data on this form as original evidence of services ordered.

By making this prior approval request I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes, and procedures of the New York State Department of Health as set forth in Title 18 of the Official Compilation of Codes, Rules, and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services, the Medicaid Management Information System Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present, or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

## eMedNY-410601 Field by Field Instructions

**Field 1 – Treatment Center Provider Number**
The eight-digit Medicaid provider identification number of the treatment center that is ordering the trip/s is entered in this field. This number will always be a Medicaid Provider Identification Number and not a license number. Right justify the information as shown in the example below.

Example:

| TREATMENT CENTER PROVIDER NUMBER | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Field 2 – Name, Address and Telephone (Treatment Center Provider)**
Enter the name, address and telephone number of the treatment center provider in this field.

**Field 4 – Beginning Date**
The first date of service for this prior authorization is to be entered in this field.

**Field 5 – Transportation Provider Number**
The eight-digit Medicaid provider identification number of the transportation provider is to be entered in the field.

**Field 6 – Name, Address and Garage (Transportation Provider)**
Enter the transportation provider's name, address and garage in the field.

**Field 7 – Destination**
This field may be left blank.

**Field 8 – Enrollee ID**
The enrollee's Medicaid identification number is entered in this field. If the number is invalid, a rejection will result and will appear on your weekly transportation ordering provider roster.

**Field 9 – Proc Code**
The appropriate procedure code is to be entered in the field.

**Field 10 – No. of Units**
The total number of one-way trips is to be entered in this field. A round trip is indicated by entering 002.

**Field 11 – Cal Days [Calendar Days]**
Enter the total number of calendar days to cover the entire period of the prior authorization in this field.

**Field 12 – Enrollee Name**
The enrollee's name is entered in this field, last name first.

**Field 13 – Address**
This field may be left blank by the ordering practitioner.

**Field 14 – Wheelchair**
Indicate whether or not the enrollee uses a wheelchair.

Y – Yes
N - No

**Field 15 – Date of Birth**
Enter the enrollee's date of birth in this field.

**Field 16 – Sex**
Enter the enrollee's sex in this field.

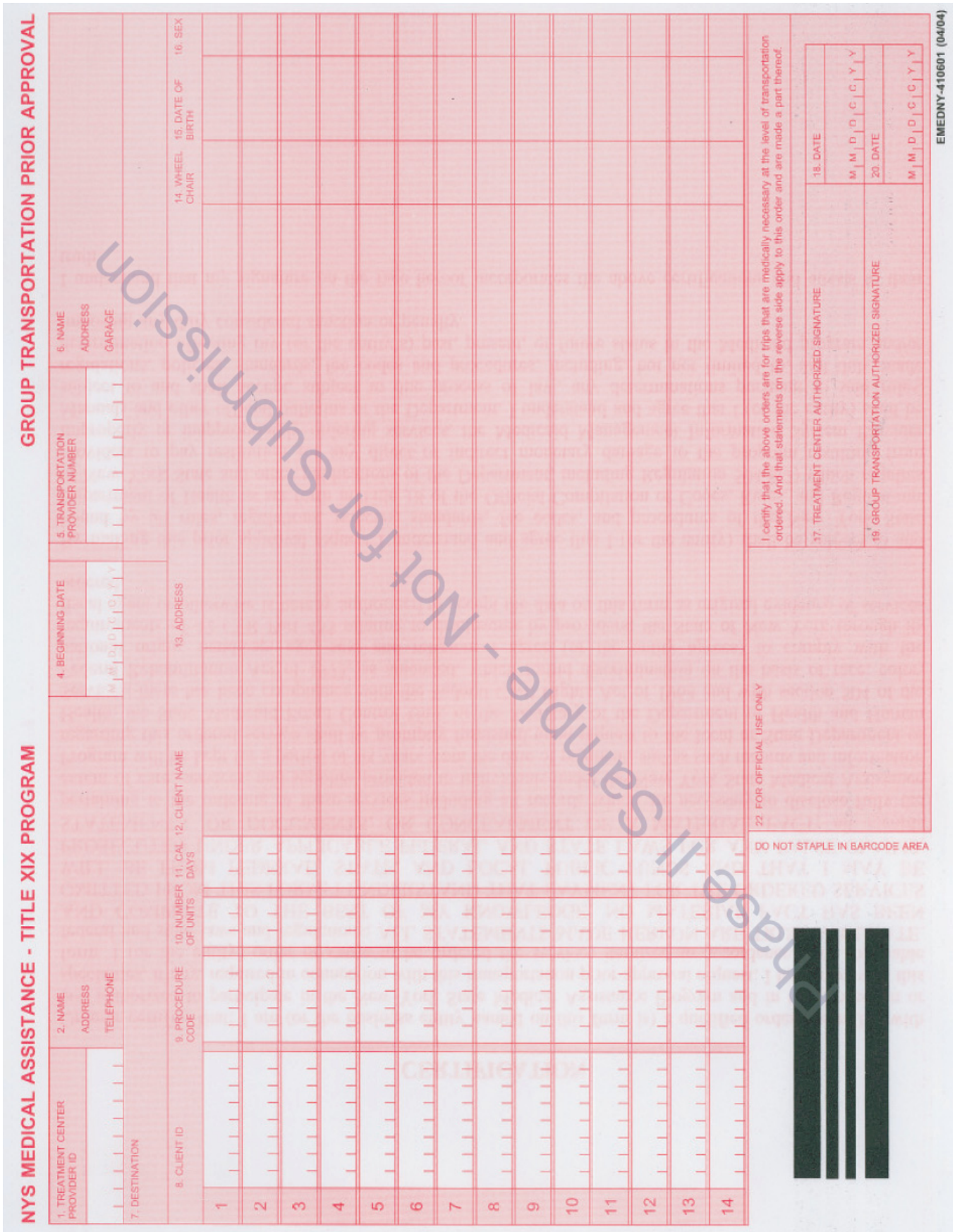
**Field 17 – Treatment Center Authorized Signature**
An authorized agent for the treatment center provider **must** sign the form in this field.

**Field 18 – Date**
Enter in this field the date the form was signed.

**Field 19 – Group Transportation Authorized Signature**
An authorized agent for the group transportation provider **must** sign the form in this field.

**Field 20 – Date**
Enter in this field the date the form was signed by the group transportation provider.

**Field 22 – For Official Use Only**
LEAVE THIS FIELD BLANK.


NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM
GROUP TRANSPORTATION PRIOR APPROVAL
1. TREATMENT CENTER PROVIDER ID
2. NAME
ADDRESS
TELEPHONE
4. BEGINNING DATE
5. TRANSPORTATION PROVIDER NUMBER
6. NAME
ADDRESS
GARAGE
7. DESTINATION
8. CLIENT ID
9. PROCEDURE CODE
10. NUMBER OF UNITS
11. CAL DAYS
12. CLIENT NAME
13. ADDRESS
14. WHEEL CHAIR
15. DATE OF BIRTH
16. SEX
1
2
3
4
5
6
7
8
9
10
11
12
13
14
22 FOR OFFICIAL USE ONLY
I certify that the above orders are for trips that are medically necessary at the level of transportation ordered. And that statements on the reverse side apply to this order and are made a part thereof.
17. TREATMENT CENTER AUTHORIZED SIGNATURE
18. DATE
19 GROUP TRANSPORTATION AUTHORIZED SIGNATURE
20. DATE
DO NOT STAPLE IN BARCODE AREA
EMEDNY-410601 (04/04)
Phase II Sample - Not for Submission

## CERTIFICATION

Orderer certifies that: I am (or the business entity named on this form is) a qualified orderer enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this transportation prior approval request; I have reviewed this form. I (or the entity) order or cause to be ordered the services itemized in accordance with applicable federal and state laws and regulations; ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT FOR THE ORDERED SERVICES WILL BE FROM FEDERAL, STATE, AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; all records pertaining to the ordering of these services including all records which are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and as such records and information regarding this ordered service shall be promptly furnished upon request to the local or State Department of Health, the State Medicaid Fraud Control Unit, or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex, and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to accept the data on this form as original evidence of services ordered.

By making this prior approval request I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes, and procedures of the New York State Department of Health as set forth in Title 18 of the Official Compilation of Codes, Rules, and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services, the Medicaid Management Information System Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, and duly made determination affecting my (or the entity's) past, present, or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

## Where to Send Completed Request Forms

**Original** paper transportation prior authorization request forms should be mailed to:

Computer Sciences Corporation
P.O. Box 4600
Rensselaer, New York 12144.

## Obtaining More Forms

A supply of paper transportation prior authorization request forms is available by contacting the eMedNY Call Center at:

(800) 343-9000 option 1, sub-option 4.

# Section V – Ordering Provider Roster

For a transportation provider to receive prior approval to render transportation services, the identity of the physician ordering the transportation **must** be furnished to NYS Medicaid.

When the prior authorization request is approved, a copy of the roster containing the prior authorization information is sent to the ordering provider. Upon receipt of the roster, the practitioner should review the information to ensure that the patient(s) on the roster were indeed referred by the practitioner receiving the roster.

If any of the patient(s) on the roster were **not** referred for transportation services, then a copy of the roster should be sent to Computer Sciences Corporation, with a cover letter explaining that the services for the indicated patient(s) were not referred by the practitioner identified on the roster. The roster and cover letter should be sent to:

Computer Sciences Corporation
ATTN: eMedNY FRAUD
P.O. Box 4611
Rensselaer New York 12144.

# Section VI – Medicaid Managed Care Contact Information

Many New York City Medicaid clients are currently enrolling in Medicaid Managed Care plans (also known as a Prepaid Capitation Plan). If a Managed Care Plan includes the cost of transportation, **then transportation must be ordered through the Managed Care Plan**.

Any questions should be referred to the Managed Care Plan. More information on Managed Care plans can be found in the Information for All Providers – Third Party Manual online at:

http://www.emedny.org/ProviderManuals/AllProviders/index.html.

| Prepaid Capitation Plan Provider Name | Telephone Number |
|---|---|
| Health Plus Lutheran | (718) 745-0030 |
| Affinity Health Plan (Bronx PHSP) | (800) 553-8247 |
| CenterCare, Inc. (Manhattan PHSP) | (800) 545-0571 |
| Metroplus (Metropolitan Health Plan) | (800) 597-3380 |
| HIP of Greater NY | (646) 447-5000 |
| Hebrew Hospital Home, Inc. (CO-OP) | (888) 830-5620 |
| Patel, Arjunj MS (Broome County) | (607) 778-2669 |
| HomeFirst, Inc. | (718) 630-2560 or (877) 771-1119 |
| ABC Health Plan | (800) 298-2420 or (212) 675-3692 |
| HealthNOW NY, Inc. (Community Blue) | (716) 887-6900 |
| Comprehensive Care Mgmt. Corp. | (877) 226-8500 or (718) 515-8600 |
| Capital District Phys. Health Plan | (518) 641-3000 |
| Vytra HealthCare Plans, L.I., Inc. (Choice Care) | (800) 926-9530 or (631) 694-4000 |
| FIDELIS (NYS Catholic Health Plan) | (800) 749-0820 |
| SMA Managed Care (Broome County) | (607) 778-2702 |
| Driscoll, Daniel MD (Broome County) | (607) 778-2737 |
| Lourdes Primary Care Assoc. | (607) 778-2737 |
| UB Family Medicine | (716) 898-5966 |
| Senior Care Connection | (518) 382-3290 |
| Daigler, Gerald MD PCMP I (Erie County) | (716) 878-7355 |
| Rosenthal, Thomas MD PCMP II | (716) 898-5966 |
| Medical Group of Western NY PCMP III | (716) 882-1212 |
| Univ. Med. Service Erie PCMP III | (716) 898-5400 |
| Lancaster – Depew Ped. PCMP III | (716) 684-6140 |
| Service Medical PC PCMP III | (716) 592-7400 |
| Concord Medical Group PCMP III | (716) 592-4600 |
| Sheehan Memorial Hospital PCMP III | (716) 842-2200 |
| CPCP Group Inc. PCMP III | (716) 882-8989 |
| Tonawanda Pediatrics PCMP III | (716) 695-0560 |
| Family Medical Faculty Assoc PCMP III | (716) 887-8200 |
| Family Health Services | (888) 753-7585 |
| Bhard-Waj, Gaur MD | (607) 770-0004 |
| Partners in Community Care | (845) 368-5943 |

| Prepaid Capitation Plan Provider Name | Telephone Number |
|---|---|
| Group Health Inc PPO FHP | (518) 446-8010 |
| GHI HMO Select, Inc. A (Columbia County) | (518) 446-8055 |
| GHI HMO Select, Inc. A & B | (518) 446-8055 |
| Guildnet | (212) 769-6200 |
| Senior Health Partners, Inc. | (212) 870-4610 |
| Graham, David MD (Health Choice) | (716) 593-6800 |
| Depner, Chris MD (Health Choice) | (716) 593-4250 |
| Coch, William MD (Health Choice) | (607) 478-8421 |
| HIP – Suffolk | (646) 447-5000 |
| HIP – Westchester | (646) 447-5000 |
| HIP – Nassau | (646) 447-5000 |
| Healthnet (Empire Blue Cross/Blue Shield) | (800) 522-6630 |
| Independent Health Association of WNY | (716) 631-3086 |
| Independent Living for Seniors | (585) 922-2800 |
| Loretto HMO | (877) 268-5284 |
| Independence Care System, Inc. | (212) 584-2500 |
| Middletown Psychiatric Center | (914) 342-5511 ext. 3525 |
| Mohawk Valley Psychiatric Center | (315) 738-4426 |
| New York Psychiatric Institute | (212) 543-5000 |
| Pilgrim Psychiatric Center | (516) 761-2704, 2129 or 2225 |
| Rochester Psychiatric Center | (716) 473-4379 |
| Rockland Psychiatric Center | (914) 359-1000 ext. 2235 |
| St. Lawrence Psychiatric Center | (315) 393-3000 ext. 3529 |
| South Beach Psychiatric Center | (718) 667-2823 |
| Binghamton Psychiatric Center | (607) 724-1391 |
| Bronx Psychiatric Center | (718) 931-0600 |
| Buffalo Psychiatric Center | (716) 885-2261 ext. 2009 |
| Capital District Psychiatric Center | (518) 447-9611 ext. 6808 or 6971 |
| Creedmoor Psychiatric Center | (718) 464-7500 |
| Elmira Psychiatric Center | (607) 737-4740 |
| Hudson River Psychiatric Center | (845) 452-8000 |
| Hutchings Psychiatric Center | (315) 473-4980 ext. 4087 |
| Kingsboro Psychiatric Center | (718) 221-7886 |
| Manhattan Psychiatric Center | (212) 961-8700 |
| Southern Tier Psychiatric Center | (607) 737-4740 |
| Community Premier Plus, Inc. | (877) 277-4456 |
| Community Choice Health Plan Westchester | (914) 709-8400 |
| Care Plus Health Plan | (800) 535-2814 or (800) 563-5581 |
| Sale, Keith MD (Health Choice) | (716) 593-6800 |
| CAREPLUS LLC MLTC | (212) 372-6942 |
| Cusumano, Leo MD (Health Choice) | (585) 968-4137 |
| Broadlawn Health Partners (LI Hlth Partners) | (516) 336-2006 |
| Elant Choice (Health Advantage Plan, Inc.) | (845) 569-0500 |
| Americhoice of NY, Inc. | (800) 493-4647 |
| United Healthcare of NY, Inc. – Metlife | (212) 216-6824 |
| Excellus (Blue Cross/Blue Choice Option) | (585) 454-1700 |
| Managed Health | (800) 566-2678 |
| MVP Health Plan, Inc. | (518) 388-2427 |

| Prepaid Capitation Plan Provider Name | Telephone Number |
|---|---|
| Senior Network Health LLC | (888) 355-4764 |
| Total Aging in Place | (716) 250-3100 |
| Neighborhood Health Provider PHSP | (800) 558-7970 |
| NY Hospital Community Health Plan | (212) 297-5510 |
| VidaCare, Inc. SN | (212) 352-3253 |
| Fidelis (NYS Catholic Health Plan) SN | (718) 896-6500 |
| NY Presbyterian System Select Health SN | (866) 469-7774 |
| HealthFirst, Inc. PHSP SN | (212) 801-6102 |
| MetroPlus Partnership Care SN | (212) 597-8600 |
| Univera Comm. Hlth, Inc. (Buffalo Comm. Hlth Inc) | (716) 857-4448 |
| Southern Tier Priority Healthcare | (607) 795-5215 or (888) 447-8528 |
| Preferred Care Rochester HMO | (716) 325-3920 |
| Total Care – Syracuse (PHSP) | (315) 476-7921 ext. 415 |
| Partners in Health (St. Barnabus Comm Hlth Plan) | (800) 652-1332 |
| Health First PHSP | (800) 580-8540 or (212) 801-6000 |
| Suffolk Health Plan | (800) 763-9132 |
| Saeed, Azmat MD (Broome County) | (607) 748-7355 |
| FIDELIS (NYS Catholic Health Plan) | (800) 749-0820 |
| Southern Tier Pediatrics | (607) 734-3252 |
| CCM Select MLTCP | (718) 734-3252 |
| United Healthcare of Upstate NY | (877) 842-3210 or (212) 609-5600 |
| VNS Choice LTCP | (888) 867-6555 |
| Giordano, Vincent MD | (607) 778-2737 |
| Wellcare of NY | (800) 960-2530 |
| Wellcare of NY (Greene) | (800) 960-2530 |
| Hudson Health Plan, Inc. (Westchester PHSP) | (914) 631-1611 |
| Broome County MAX Program | (607) 778-2702 |
| Wellcare of NY (Orange) | (800) 960-2530 |
| Neighborhood Health Provider LLC M/M | (212) 883-0883 |
| Group Health Inc. M/M | (518) 446-8072 |
| Managed Health, Inc. M/M | (212) 801-1638 |
| Liberty Health Advantage M/M | (818) 654-3461 |
| Americhoice of NY M/M | (212) 509-5999 |
| NY Presbyterian Comm Hlth M/M | (212) 597-5594 |
| HIP Health Plan M/M | (646) 447-6200 |
| Fidelis Dual Advantage M/M | (718) 896-6500 |
| Oxford Mosaic M/M | (914) 467-1009 |
| Wellcare Health Plan M/M | (212) 337-5180 |
| Oxford Health Plans M/M | (914) 467-1009 |

# Section VII – Definitions

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

## Ambulance

A motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

## Ambulance Service

Any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is currently certified or registered by the Department of Health as an ambulance service.

## Ambulette

A special-purpose vehicle designed and equipped to provide non-emergency transport that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

Ambulettes, also known as invalid coaches, are licensed by the New York State Department of Transportation and the Taxi and Limousine Commission of the City of New York.

## Ambulette Service

An individual, partnership, association, corporation, or any other legal entity, which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care.

An ambulette service also provides the invalid, infirm or disabled with personal assistance.

## Common Medical Marketing Area

The geographic area from which a community customarily obtains its medical care and services. In New York City, this is five miles from one's residence.

## Ordering Practitioner

The Medicaid enrollee's attending physician or other medical practitioner who has not been excluded from enrollment in the Medicaid Program and who is requesting transportation on behalf of the enrollee in order that the enrollee may obtain medical care or services which are covered under the Medicaid Program.

The ordering practitioner is responsible for initially determining when a specific mode of transportation to a particular medical care or service is medically necessary.

## Personal Assistance

The provision of physical assistance by a provider of ambulette services or the provider's employee to a Medicaid enrollee for the purpose of assuring safe access to and from the enrollee's place of residence, ambulette vehicle and Medicaid-covered health service provider's place of business.

Personal assistance is the rendering of physical assistance to the enrollee in:

- walking, climbing or descending stairs, ramps, curbs or other obstacles;
- opening or closing doors;
- accessing an ambulette vehicle; and
- the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

**In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance.**

> An enrollee who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

## Prior Authorization

Designated agents of the Department of Health or social services district's determination that payment for a specific mode of transportation is essential in order for a Medicaid enrollee to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the enrollee's transportation costs.

## Transportation Services

Transportation by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the enrollee's medical condition.

## Undue Financial Hardship

Transportation expenses which the Medicaid enrollee cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.