NEW YORK STATE
MEDICAID PROGRAM

INFORMATION FOR ALL PROVIDERS

GENERAL POLICY

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Section I – Recipient Information

This section provides recipient information applicable to the Medicaid program.

Recipient Eligibility

The New York State Department of Health (DOH) exercises overall supervision of the Medical Assistance Program. Recipient eligibility, however, is handled by the fifty-eight local departments of social services and the New York City Human Resources Administration. These local agencies are vested with the authority to review applications for Medical Assistance (MA or Medicaid) and determine Medicaid eligibility.

The following groups are eligible for Medicaid in New York State:

- Citizens and certain qualified aliens 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 certified disabled, and not pregnant, whose income and resources are below the Public Assistance Standard of Need.
- Citizens and certain qualified aliens 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 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. As of January 1, 1999, this will include 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 Beneficiary (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). For more information see **Qualified Medicare Beneficiary** further ahead in this section.

Identification of Recipient Eligibility
An eligible recipient must present an official permanent plastic Common Benefit Identification Card (CBIC) whenever he/she requests medical services or supplies. However, presentation of a CBIC alone is not sufficient proof that a recipient is eligible for services. Each of the Benefit Cards must be used in conjunction with the electronic verification process. Through this process the provider must be sure to verify if the recipient has any special limitations or restrictions. The permanent plastic CBIC does not contain eligibility dates or other eligibility information. If you do not verify the eligibility and extent of coverage of each recipient each time services are requested, you will risk the possibility of nonpayment for services which you provide. Therefore, eligibility information for the recipient must be determined via the MEVS.

Eligible recipients 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 recipients. If a card is required, a non-photo CBIC will be issued by the local department of social services. It is the responsibility of the voluntary child care agency or the residential health care facility to give the recipient's Medicaid ID Number to other service providers; those providers must complete the verification process via MEVS to determine the recipient's eligibility for Medicaid services and supplies. The State cannot compensate a provider for a service that was rendered to an ineligible person.

Services Provided 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 provided 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 other 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 local department of social services;
- 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 (also known as the Child/Teen Health Program);
- 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 a written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

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

Qualified Medicare Beneficiary (QMB)
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 beneficiaries with low income and very limited assets. These

individuals are known as QMBs.

QMBs are individuals who have applied to Medicaid through the local department of social services and have been determined eligible for Medicaid payment, as appropriate, of Medicare premiums, deductibles and coinsurance for Medicare approved services. Not all Medicaid recipients who have Medicare Part B coverage are QMBs.

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

For QMBs, one of the two unique identifiers below must appear in the MEVS response in order to confirm QMB eligibility.

- **MDCR COIN/DEDUC:** This message and/or coverage code **09** are returned in the **Medicaid** coverage field and identify a Qualified Medicare Beneficiary. This QMB response means that **only** coinsurance and deductible payments, as appropriate, for **Medicare approved** services are reimbursable for this recipient.

- **QMB:** This message is returned in the **Medicare** coverage field and indicates that the recipient is a Qualified Medicare Beneficiary. This QMB response means that **only** coinsurance and deductible payments, as appropriate, for **Medicare approved** services are reimbursable for this recipient. **PLEASE NOTE:** When the QMB message is returned **without** coverage code **09** or MDCR COIN/DEDUC (as in #1 above), this means that the recipient has Medicaid benefits as well as QMB benefits. For example: The message **MA ELIGIBLE** or coverage code **01** may be returned in the Medicaid coverage field along with **QMB** in the Medicare field.

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 New York State Medicaid Program.

Enrollment in Medicaid does not mandate practitioners to render services to all Medicaid recipients who request care. If a private payment arrangement is made with a Medicaid recipient, the recipient 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. In structuring their practice, practitioners must ensure that any limitations are based on criteria which are not discriminatory and continue to comply with "Civil Rights" (see below).

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.

Recipient's Right to Refuse Medical Care

Federal and State Laws and Regulations provide for Medicaid recipients 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

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 recipients, is considered confidential and cannot be released without the expressed consent of the recipient. Medical records and information which are transmitted for the purpose of securing medical care and health services are received and held under the same rule of confidentiality. All providers must comply with these confidentiality requirements.

The DOH, its various political subdivisions, local departments of social services and fiscal agent, 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. Therefore, authorized representatives of the Department, its subdivisions, local departments of social services and fiscal agent 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 Fiscal Agent, and to Federal, State and local program officials for purposes directly connected with the administration of the Medicaid Program.

When Medicaid Recipients Cannot be Billed

This is the policy of the Medicaid program concerning the requirements related to requesting compensation from Medicaid recipients, including Medicaid recipients who are enrolled in a managed care plan and in Family Health Plus.

Acceptance and Agreement

When a provider accepts a Medicaid recipient as a patient, the provider agrees to bill Medicaid for services provided or, in the case of Medicaid managed care enrollee, agrees to bill the recipient's managed care plan for services covered by the contract. The provider is prohibited from requesting any monetary compensation from the recipient, or his/her responsible relative, except for any applicable Medicaid co-payments. A provider may charge a Medicaid recipient, including a Medicaid recipient enrolled in a managed care plan, ONLY when both parties have agreed PRIOR to the rendering of the service that the recipient 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 recipient's Medicaid managed care plan may not bill Medicaid fee-for-service for any services included in the managed care plan, with the exception of family planning services. Neither may such a provider bill the recipient for services that are covered by the recipient's Medicaid managed care contract unless there is prior agreement with the recipient that he/she is being seen as a private patient as described above. The provider must inform the recipient that the services may be obtained at no cost to the recipient from a provider that participates in the recipient's managed care plan.

Claim Submission

The prohibition on charging a Medicaid recipient applies when a participating Medicaid provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required timeframe. It also applies when a claim is submitted to CSC or the recipient'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 recipient, 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 recipient as a Medicaid patient. Providers may, however, use any legal means to collect applicable unpaid Medicaid co-payments.

Emergency Medical Care

A hospital that accepts a Medicaid recipient as a patient, including a Medicaid recipient 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 recipient 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 recipient in the facility is enrolled in the Medicaid program. When reimbursing for ER services provided to Medicaid recipients 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 recipient's local department of social services (e.g., investigation of recipient eligibility issues), the provider must contact the local department of social services 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 recipient (identified via MEVS). Local Professional Directors can be contacted at the area offices of the State Office of Health Systems Management. The addresses and telephone numbers for the area offices are listed in **Information For All Providers, Inquiry**.

The Local Professional Director is an individual who, under Section 365-b of the New York State Social Services Law, serves under the general direction of the Commissioner of Social Services. He, or she, in cooperation with the Commissioner of Health, 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. This individual may also be known as a local medical director or reviewing health professional.

How to Request Prior Approval
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 found in **Information For All Providers, Inquiry**.

When a provider determines that a service requires prior approval, he/she must obtain a prior approval number by following the procedures outlined in the Billing Guidelines and Policy Guidelines sections of the specific provider manual. The Local Professional Director will review the proposed course of treatment and then submit his/her approval or disapproval to the DOH and to the provider.

The DOH will enter the information into the MMIS for use in processing the provider's claim.

If either the provider or recipient feels that a service which has been recommended by the provider has been unjustifiably denied, the recipient may request a fair hearing. The recipient should be referred to his/her local department of social services or the New York State Office of Temporary and Disability Assistance for information on the fair hearing process.

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. An emergency is defined as care for patients with severe, life threatening, or potentially disabling conditions that require immediate intervention. In the event of an emergency, approval must be requested after the service is rendered.

It should be noted that prior approval does not automatically ensure payment. Even if a service has been prior approved, the provider must still verify a recipient's eligibility via 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.

Please note that services for which the provider has received prior approval, are not subject to Utilization Thresholds.

The provider must include on the appropriate claim form 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 a recipient, and that recipient becomes ineligible before the plan is completed, payment for services provided outside the recipient's eligibility period shall not be made except where:

- The recipient is enrolled in the Physically Handicapped Children's Program and has an approved treatment plan; or

- Failure to pay for services would result in an undue hardship to the recipient.

When a provider's treatment plan for a recipient 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 recipient. 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. However, all efforts will be made by the local department of social services to secure a new provider for the recipient so the plan can be reevaluated 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.

It should be noted that prior authorization does not automatically ensure payment. Even if a service has been prior authorized, the provider must still verify a recipient’s eligibility via MEVS before service is provided 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 Medicaid.

There are certain services which always require prior authorization, e.g., personal care services and non-emergency transportation. Each specific 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 payor of last resort. If a recipient has a third-party insurance coverage, he/she is required to inform the local department of social services of that coverage and to use its benefits to the fullest extent before using Medicaid.

Examples of third-party resources are Medicare, Worker's Compensation, family health insurance carried by an absent parent, Veteran's benefits, CHAMPUS, and Blue Cross/Blue Shield.

The Providers' Responsibilities

- **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. It should be noted that 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 recipient can be found in **Information For All Providers, Third Party Information**.

- **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. Additional information and record-keeping requirements can be found in Section II.

Explanation of Third-Party Resources

Medicaid will supplement an eligible recipient's insurance benefits as follows:

- **Medicare (Title XVIII of the Social Security Act)**
  Medicare provides hospital (Part A) and supplementary medical (Part B) coverage to eligible individuals. Instructions on claiming procedures for combination Medicare/Medicaid claims (known as "cross-over" claims) can be found in the Billing Guidelines of each specific provider manual.

  Providers of care, services, supplies or equipment who are enrolled in Medicaid must accept assignment of a person's right to receive Medicare Part B payments and must not seek to recover Medicare Part B deductible or coinsurance amounts from this group of eligible individuals.

  Medicaid may not be billed for Medicare covered services for which the provider agrees not to charge a beneficiary under the terms of its Medicare provider agreement or for services for which the beneficiary cannot be held liable by the provider under existing Medicare regulations.

  Medicare coverage for a Medicaid-eligible recipient can be obtained via MEVS. MEVS identifies the type of Medicare coverage the recipient is eligible for and the Health Insurance Claim Number (HIC).

  For example, if the recipient has only Part A Medicare coverage, the MEVS response

would be:

Medicare A HIC [12 digit #]

A recipient who has only Part B coverage, would have a MEVS response:

Medicare B HIC [12 digit #]

The MEVS response for both Part A and Part B coverage would be:

Medicare AB HIC [12 digit #]

- **Worker's Compensation**
  Worker's Compensation benefits include all necessary medical care arising from job-related injury or illness. Therefore, no Medicaid payments will be made for services covered by Worker's Compensation. The availability of Worker's Compensation may not be indicated as a result of eligibility verification via MEVS.

  In case of work-related injuries or illness, providers and recipients may obtain information from the nearest Worker's Compensation Board Office or the recipient's employer.

- **Veterans Benefits (CHAMPUS/CHAMPVA)**

  - General - CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of Veterans Administration) are similar programs administered by the Department of Defense except that the Veterans Administration determines eligibility of persons seeking to establish entitlement to CHAMPVA coverage. CHAMPUS provides benefits for health care services furnished by civilian providers, physicians, and suppliers to retired members of the Uniformed Services and to the spouses and children of active duty, retired and deceased members. The term "Uniformed Services" include Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the U.S. Public Health Services and the National Oceanic and Atmospheric Administration. CHAMPVA provides similar benefits for the spouses and children of veterans who are entitled to permanent and total disability benefits and to widows and children of veterans who died of service connected disabilities.

  - Effect of Medicare Eligibility on CHAMPUS/CHAMPVA Entitlement - CHAMPUS/CHAMPVA beneficiaries, other than dependents of active duty members, lose their entitlement to CHAMPUS/CHAMPVA if they qualify for Medicare Part A on any basis other than the premium - Hi provisions. Individuals who are eligible for Medicare Part B benefits only, as well as dependents of active duty members, are also eligible for CHAMPUS benefits.

- The availability of CHAMPUS/CHAMPVA medical coverage can be determined via MEVS. The MEVS response would be: **CA**

  Descriptions of the coverage codes can be found in **Information For All Providers, Third Party Information**.

- **Insurance for Injuries Arising from Accidents**
  In such cases, medical payments may be available from Worker's Compensation, auto or homeowner's liability insurance policies, etc. If no insurance is in effect, a court action may be taken to cover medical expenses resulting from the accident. In case of a pending court action, Medicaid may be authorized if the individual in question is eligible for Medicaid, and if an assignment of proceeds is made to the local department of social services by the recipient.

  Medicaid eligible individuals injured in an automobile accident in New York State are usually covered under the No-Fault Insurance Law. The injured recipient may receive no-fault insurance benefits. Those benefits are to be applied specifically for necessary medical care and services; Medicaid will not duplicate payment for that care. No-fault benefits must be utilized before Medicaid.

- **Other Insurance**
  When a Medicaid recipient has other insurance (e.g., basic health and medical insurance such as Blue Cross/ Blue Shield, major medical insurance, disability insurance), benefits from that insurance must be utilized first. Supplementary payments may be made by Medicaid when appropriate.

Section II – Provider Information

This section provides provider information applicable to the Medicaid program.

Provider Eligibility

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.

(Please refer to **Information For All Providers, Inquiry** for provider enrollment contact information.)

Providers must inform DOH of any changes in their status as enrolled providers in the Medicaid Program, e.g., change in address, change in specialty, change of ownership or control.

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. In addition, continued participation in the Medicaid Program by providers is subject to re-enrollment upon notice by the Department.

Duties of the Provider
By enrolling into the Medicaid Program, a person agrees:

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

- To submit claims for payment for services actually furnished, medically necessary and provided to eligible persons;

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

- To comply with the rules, regulations and official directives of 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 the 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 (90) days of receipt of the application. If the applicant cannot be fully evaluated within ninety (90) 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 a 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 a 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 (2) 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 person's participation in the Medicaid Program may be terminated by either the person or the Department upon 30 days written notice to the other without cause. In addition, a person's participation in the Medicaid Program may be terminated under the following circumstances:

- When a person is suspended or excluded from the Medicare Program;
- When a person'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 person fails to maintain an up-to-date disclosure form;
- When a person's ownership or control has substantially changed since acceptance of his/her enrollment application;
- When at any time, the Department discovers that the person submitted incorrect, inaccurate or incomplete information on his/her application and where provision of correct, accurate or complete information would have resulted in a denial of the application.

Note: The above material is intended to summarize the provisions of the Department's regulations dealing with unacceptable practices, audit and enrollment by and of Medicaid providers. 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

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. (Please refer to **Information For All Providers, Inquiry** for provider enrollment contact information.)

Description of Policy
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 recipient only under the

following circumstances:

- The provider practices in the "common medical marketing area" of the recipient's home local department of social services as determined by the Local Professional Director;

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

Please note that 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 recipients.

Inpatient Care (non-emergency)
The New York State 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 recipient will be most effectively served because of his/her social situation or when the inpatient care 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 (e.g., 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 recipient with an out-of-state medical inpatient facility is required to document that the needed services are not readily available within New York. Approval is based on the determination of the New York State DOH Prior Approval Office. For a mentally disabled recipient, approval is also subject to the concurrence of the State Department of Mental Hygiene agency which has programmatic responsibility for programs which provide services to this patient population within New York State, that the care should be obtained out-of-state.

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 recipients. Providers must furnish information regarding any payment claimed

to authorized officials upon request of the DOH or the local department of social services.

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 recipient to whom care is rendered. The minimum content of the recipient record includes:

- Recipient identification (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 recipient 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 recipients must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform with these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

Medical Review

Medical reviews are conducted both at the local level and the State level. On the local level, the appropriate Local Professional Director may review and evaluate individual provider performance, as well as total program operation. The Local Professional Director will be assisted in review and evaluation by feedback of information from the State review process.

At the State level, the MMIS will, based on the data supplied in the billing process, generate the following types of information:

- Statistical profiles, by individual provider, of medical activity and frequency of service;
- Errors in billing or patterns of poor billing procedures;
- Indications of unacceptable practices, e.g., abusive or fraudulent activity;
- Generalized data on quality of care.

From time to time the Department may notify the provider either directly through State

staff, or through the Local Professional Director of specific concerns regarding Medicaid billings or practices in order to assist the provider to properly utilize the Medicaid Program. For example, once aware of any errors in billing, the provider will be able to expedite payment by correcting his/her billing procedures.

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 recipient'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 recipient's period of eligibility;
- Which were not rendered, ordered, or referred by a restricted recipient'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 is initially received by the Department more than ninety days after the original date of service (see **Information For All Providers, General Billing** for applicable exceptions);
- Which require prior approval or authorization, but for which such approval/authorization was not obtained or was denied;
- For which third parties e.g., Medicare, Blue Cross/Blue Shield are liable;
- Which are rendered out-of-state but which do not meet the qualifications outlined in the section under 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 recipient's personal preference;
- Which are rendered in the absence of authorization from MEVS in accordance with

Utilization Threshold requirements. Exceptions to this policy include instances when a provider uses one of the "SA EXCP CODE(S)" 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 a recipient has reached the Utilization Threshold established for a specific provider service type unless one of the following conditions is satisfied:

  - ► The recipient has been exempted from the Utilization Threshold;
  - ► The recipient 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. The definitions are:

    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 recipient's health in serious jeopardy.

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

    1. An increase in the severity of symptoms;
    2. The development of complications;
    3. Increase in recovery time;
    4. The development of an emergency situation.

Unacceptable Practices

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 New York State Department of Social Services (18 NYCRR) 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 Medical Assistance Program. For the complete list of Unacceptable Practices you may refer to Chapter II, Part 515.2. of Title 18 of the Official Codes, Rules and Regulations of the State of New York which can be found by doing a search at:
http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm.

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 to 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 participating in the Medicaid Program;
- Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing a Medicaid recipient 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 a recipient based upon the recipient's inability to pay a co-payment; and
- Failure to use the VeriFone Omni 3750 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 (e.g., 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 60 days of the date of the notice of agency action notifying the person of the unacceptable practice. In the event 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 doing a search 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 recipients 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 in 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 of 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 recipients;

- 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 the 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 recipient.

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 Medical Assistance 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 or limitation 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 Department may grant reinstatement only if it is reasonably certain that the violation(s) that led to sanction will not be repeated.

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.

Note: The above material is intended to summarize the provisions of the Department's regulations dealing with unacceptable practices, audits and enrollment by and of Medicaid providers. For a more extensive and precise definition of his/her rights and obligations, persons are referred to parts 504, 515, 517, 518 and 519 of Title 18 of the Official Codes, Rules and Regulations of the State of New York which can be found by doing a search at:
http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm

Audits

The DOH is responsible for monitoring the Medical Assistance 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 also 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.

Audits Process

The Department may either conduct an on-site field audit of a person's records or it may conduct an in-house review utilizing electronic 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 Medical Assistance 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 audit report or notice of proposed agency action is sent to the provider. Issuance of the draft report or notice of proposed 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 audit 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 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 withhold 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 or 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;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Referral to Other Agencies
Department officials are responsible for identifying, investigating, and then referring to law enforcement agencies cases of suspected illegal activity. Along with Local Professional Directors, they will provide assistance to the law enforcement agencies during the investigation. The DOH will receive reports of all proceedings.

Prohibition Against Reassignment of Claims: Factoring

A Factor is defined in Federal Medicaid Regulations to be 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.

The practice of factoring is prohibited by Federal Medicaid Regulations. Federal Medicaid Regulations specify that no payment for any care or service provided to a Medicaid recipient 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 recipient 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 the payment.

Section III – Program Information

This section provides program information applicable to the Medicaid program.

Child/Teen Health Program

The Child/Teen Health Program (CTHP) is New York State's approach to the Federal program of Early, Periodic Screening, Diagnosis and Treatment for children (EPSDT). The program is designed to assure that a full range of comprehensive, primary health care services is available to Medicaid eligible children under age 21 on a regular basis.

The standards for CTHP and the frequency with which examinations should occur generally follow the recommendations of the Committee on Standards of Child Health of the American Academy of Pediatrics; they were developed for the Program with the advice and consultation of an ad hoc group from the New York State Pediatric Society.

CTHP strives to get Medicaid children under some form of ongoing primary care which will aid in preventing disease and in detecting potentially disabling conditions before they become chronic or permanent.

Physically Handicapped Children's Program

The Physically Handicapped Children's Program (PHCP) is a Federal grant program under the Social Security Act (the Crippled Children's Program) 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 the DOH's Bureau of Maternal and Child 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 for cardiac defects, hearing loss, hydrocephalus, convulsive disorders, dento-facial abnormalities, and many other conditions. Treatment for long-term diseases, e.g., 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.

A Child's Eligibility
To participate in the PHCP, a child must first be determined to be medically eligible, e.g., to have one of the defects or disabilities referred to above. A child under 21 who, in a physician's professional judgement, may be eligible for 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 medical 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 local department of social services for a determination of Medicaid eligibility. If the child's family is financially eligible for Medicaid, services for the child will be paid for by Medicaid funds. If the child's family is not financially eligible for Medicaid, services will be paid for by 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 DOH.

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 Fiscal Agent.

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 family cease to be eligible for Medicaid 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.

Essentials for Reimbursement
Prior approval of PHCP-covered services provided to Program participants is required

as a condition of reimbursement for those services. The CBIC is not sufficient authorization; its presentation by the client will not guarantee reimbursement. The verification process via MEVS must be completed to determine the recipient's eligibility for Medicaid services and supplies, and the claim must be otherwise payable in accordance with the requirements outlined in the Billing Guidelines section of each specific manual.

If a family consults a general practitioner or a specialist for a PHCP covered condition whose expertise does not include that condition, the child must be referred to the appropriate specialist or special facility.

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 residents. 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. Recipients 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 recipients 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 recipients, also apply in cases involving family care residents.
Individuals in the Family Care Program must be determined eligible for Medicaid by the Cooperative Institutional Section of the DOH's Office of Medicaid Management. Residents determined eligible for medical assistance are issued a permanent plastic CBIC (DSS-3712).

Utilization Threshold Program

The Medicaid Program has been restructured in New York State 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 in a Year
Pharmacy (prescription drugs including initial prescriptions, refills, over the counter medicine and medical/surgical supplies)	40 items if the recipient is: • under 21 • 65 or over • certified blind or disabled • single caretaker of a child • under 18 43 items if the recipient is: • 21 to 65 • not certified blind or disabled • not a single care taker 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 recent historical information on service use from the MMIS.

The threshold levels are high enough so that most Medicaid recipients will not be affected. It will be necessary, however, for providers to verify eligibility and to obtain authorization (through MEVS) for those services that they provide.

The potential provider of a service will be required to access MEVS to receive provider/recipient service data to ascertain whether the recipient has reached the particular threshold for that type of service. If the recipient has not reached his/her service limitation, MEVS will inform the provider that the service is approved and record that approval for transmission to the MMIS Fiscal Agent. Without such approval, the provider's claim for service will not be paid by the Fiscal Agent. Exceptions to this are situations such as emergency or urgent medical care when the provider will use one of 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. The provider will be required to submit a "Threshold Override Application" form to the Medicaid Override Application System (MOAS) to request such an increase to or

exemption from a utilization threshold.
In order to help avoid a disruption in a recipient's medical care, a "nearing limits" letter will be sent to the recipient, 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 recipient to contact his/her provider who should submit a Threshold Override Application form to increase the recipient'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 a recipient reaches his/her utilization threshold, a letter will be sent to the recipient and the provider will be alerted to this fact via a message on the MEVS terminal.

Certain Medicaid recipients will be exempt from most utilization thresholds because they receive their medical care through managed care programs; e.g., Health Maintenance Organizations, prepaid capitation service plans.

There are also some services which are exempt from utilization threshold and the recipient's use of these services is not limited under this program. Such services as Family Planning, Methadone Maintenance Treatment, certain obstetric services, Child/Teen Health Program services and kidney dialysis are among those included in this group.

Recipient Restriction Program

The Recipient Restriction Program (RRP) is an administrative mechanism whereby selected Medicaid recipients with a demonstrated pattern of abusive utilization of Medicaid services must receive their medical care from a designated primary provider(s). The RRP has as its goal the elimination of abusive utilization behavior as well as the promotion of quality care for restricted recipients through coordination of the delivery of select medical services.
In support of these goals, the RRP requires that recipients with demonstrated patterns of abuse receive their care from one or more primary providers. The DOH and local department of social services may restrict recipients to the following provider types: physicians, clinics, pharmacies, inpatient hospitals, podiatrists, dentists and durable medical equipment dealers. These restrictions may be imposed individually or in conjunction with one another. To promote coordinated medical care, the RRP prohibits restricted recipients from obtaining certain ancillary services such as lab and transportation ordered by non-primary providers. Billing information relating to the RRP is found in the Billing Guidelines section of each specific provider manual.

MEVS Implications for the RRP

It is important for all providers to properly access MEVS to ensure that the recipient is eligible and to (1) avoid rendering services to a patient who is restricted to another provider; and/or (2) ensure that ordered services are provided at the request of a restricted recipient's primary provider or a provider to whom the recipient was referred by his/her primary provider. Please refer to your MEVS Provider Manual for instructions on MEVS transactions.

Medicaid Co-Payments

Nominal co-payments for Medicaid recipients on certain specific services and supplies were implemented on November 1, 1993. 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 - $.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, incontinent 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 - $2.00 Brand Name, $.50 Generic.

Note: 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.

There is a co-payment maximum of $100.00 per recipient per year for all co-payments incurred. The co-payment year runs from April 1 through March 31. Additionally, recipients 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 MEVS to enter the applicable co-payment amount, if any is due for the service being provided. When accessing MEVS, the provider will be given information as to the recipient's exemption status for co-payments. Specific instructions on the MEVS information obtained by the provider may be found in the MEVS Manual.

The following recipients are exempt from all Medicaid co-payments:

- Recipients under age 21;
- Pregnant women - exempt during pregnancy and for two months following the month in which the pregnancy ends;

- Recipients enrolled in managed care programs;
- Recipients enrolled in a Comprehensive Medicaid Case Management Program (CMCM) or Service Coordination Program;
- Residents of OMH and OMRDD certified Community Residences;
- Recipients enrolled in an OMRDD Home and Community Based Services (HCBS) Waiver Program;
- Nursing Home residents;
- Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);
- Recipients enrolled in the Home and Community Based Services Waiver for Persons with Traumatic Brain Injuries (HCBS/TBI Waiver).

Note: A new Recipient Restriction Exception Code (Value 81) has been established to identify HCBS/TBI participants and systematically exempt them from co-payments and utilization thresholds. This code will also indicate that the recipient is a HCBS/TBI waiver participant and therefore exempt from Medicaid co-payments. The quarterly letter can continue to be accepted as verification of the HCBS/TBI waiver participant's exemption from co-payments.

Additionally, the following co-payment exemptions apply to only specific types of providers:

- All emergency services and items delivered by all providers;
- Emergency room visits for emergency or urgent care;
- Methadone Maintenance Treatment Program (MMTP), Mental Health clinic visits, Mental Retardation clinic visits, Alcohol and Substance Abuse clinic visits;
- Family planning services and items;
- Tuberculosis Directly Observed Therapy;
- Psychotropic and Tuberculosis Drugs.

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 preventive, primary and specialty services and managed care organization (MCO) is

responsible for assuring that enrollees have access to a comprehensive range of 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 recipient enrolled with a MCO remains eligible for the full range of medical services available in the Medicaid program. However, an enrolled recipient is required to access most health care services through his/her MCO.

When a recipient is determined to be eligible for Medicaid, he/she has the opportunity to enroll with a MCO, but not all recipients will be enrolled in a MCO. Certain individuals are excluded from participating in Medicaid managed care. These exclusions are:

- Individuals who "spend down" to obtain Medicaid eligibility;
- Foster care children residing in voluntary child caring agencies;
- Medicare/Medicaid dual eligibles;
- Residents of State-operated inpatient psychiatric facilities;
- Residents of residential treatment facilities for children and youth;
- Recipients 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 Recipient Program with a primary physician, clinic, dental, DME, or inpatient provider;

- Recipients who have other third party insurance so that managed care enrollment is not cost-effective.

MEVS Implications for Managed Care
Providers must check MEVS prior to rendering services to determine the recipient's Medicaid eligibility and the conditions of Medicaid coverage. If the Medicaid recipient is enrolled with a MCO, the first MEVS coverage message will indicate, "Eligible PCP".

Note: PCP stands for Prepaid Capitation Plan (or MCO). To determine if you can bill MMIS, you must read beyond the "Eligible PCP" message to determine the insurance and coverage codes which identify the MCO and the services which are covered by the respective MCO. Please refer to your MEVS Provider Manual for instructions on MEVS 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.

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