COMPUTER SCIENCES CORPORATION
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER MANUAL
PHARMACY

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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 Medical Assistance Program (Medicaid). 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 New York State Medicaid Program and the Medicaid Management Information System (MMIS) have been designed to reduce payment time, to provide quick and accurate information in response to Provider inquiries and to encourage the delivery of improved health care.

INTRODUCTION

1.0 INTRODUCTION

The New York State Department of Social Services (DSS) is the single State agency responsible for the administration of the New York Medical Assistance Program under Title XIX of the Social Security Act. The primary purpose of the Medical Assistance Program is to make covered health and medical services available to eligible individuals. As the single State agency, DSS promulgates all necessary regulations and guidelines for program administration. The Department is required to maintain a Medicaid plan for the State 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, DSS has delegated certain tasks to the New York State Department of Health (DOH) and the New York State Office of Mental Retardation and Developmental Disabilities (OMR/DD). The Department of Health has responsibility for the development of professional standards for the program, development of rates and fees for medical services, hospital utilization review and professional consultation to local Social Services officials for determining adequacy of medical services submitted for Medicaid reimbursement. For services provided in ICF-DDs, OMR/DD has responsibility for the development of professional standards, the establishment of rates and utilization review.

All fees and rates for the Medicaid Program are promulgated by the Director of the New York State Division of the Budget.

1.1 MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

Chapter 639 of the Laws of the State of New York, 1976, mandated that DSS design, develop, implement and operate a statewide Medicaid Management Information System (MMIS). The MMIS is a computerized system for claims processing which also provides information upon which management decisions can be made. The New York State MMIS 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.

DSS 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 MMIS 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 Relations personnel in order to train providers in what MMIS is and how to submit claim forms; responds to provider mail and telephone inquiries; maintains and issues forms, notices, and manuals to providers.

1.2 KEY FEATURES

The MMIS has several key features which enable the system to achieve its objectives.

- Claims Payment
  This aspect of MMIS 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
  The system will have the flexibility to process individual claim lines on the claim form separately. It will not deny payment of the entire invoice if one line is pended or requires manual pricing.

- 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 the Inquiry Section of this Manual.

- Service Bureaus
  The fiscal agent will cooperate with the Provider's computer service bureau to ensure that the automated claim input meets MMIS requirements.

- Provider and Recipient Eligibility

  The DSS is responsible for the determination of eligibility of both Providers and Recipients in the New York Medicaid Program.

- Service Limitations and Exclusions

  The DOH maintains the responsibility for determining covered services and exclusions in the Medicaid Assistance Program.

- Continuing Communications

  To ensure a flow of information from the State and fiscal agent to the Providers, community bulletins, newsletters and updates to the manual will be mailed periodically.

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2.1 GENERAL INFORMATION

2.1.1 Recipient Eligibility
Who is Eligible

The New York State Department of Social Services exercises overall supervision of the Medical Assistance Program. Recipient eligibility, however, is handled by the fifty-seven county 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 Medical Assistance in New York State:

- Persons who are in receipt of or eligible for cash assistance under:

  · the Aid to Dependent Children Program (ADC)
  · the Home Relief Program (HR)
  · the Supplemental Security Income Program (SSI)

- Those persons who do not qualify for cash assistance, but whose income and resources are insufficient to meet their medical needs, may be eligible for Medical Assistance as "MA-Onlys" if they meet certain income and resource criteria. These individuals may be under 21 years old, pregnant women and infants, certified blind or disabled persons, individuals over 65 years of age and single individuals between the ages of 21 and 65 years old.

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). When this is the only eligibility an individual has, coverage is limited to payment of Medicare premiums, deductibles and coinsurance, as appropriate. An individual may also have these benefits as a supplement to other Medicaid eligibility. QMB status is identified through the Electronic Medicaid Eligibility Verification System (EMEVS) described in Section 2.2.5.

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, the Common Benefit Identification Card issued to a recipient is not sufficient proof that the recipient is eligible for services. The permanent plastic Common Benefit Identification Card does not contain eligibility dates or other eligibility information. Therefore, eligibility information for the recipient must be determined via the Electronic Medicaid Eligibility Verification System (EMEVS). In addition, EMEVS must be used to determine whether the recipient has reached the Utilization Threshold for certain provider service types, as described in Section 2.1.22.

Eligible recipients in voluntary child care agencies and residential health care facilities are issued Medicaid ID Numbers which are maintained only 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 EMEVS 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.

If a recipient's permanent plastic ID card has been lost, stolen or damaged, the recipient will be issued a replacement paper Common Benefit Identification Card (DSS-3713) until a new

plastic card can be re-issued. This temporary card carries an expiration date after which the card cannot be used. Verification of eligibility must be completed via EMEVS whenever a temporary replacement card (DSS-3713) is presented. In some circumstances, the recipient may present a Temporary Medicaid Authorization (DSS-2831A). This document is issued by the local Department of Social Services when the recipient has an immediate medical need and a permanent plastic ID card has not been received by the recipient. This document is a guarantee of eligibility for the authorization period indicated on the form (maximum 15 days). Verification of eligibility via EMEVS is not required. Questions regarding eligibility should be directed to the local Department of Social Services issuing the DSS-2831A.

NOTE: Each of these documents is described in greater detail in the following sections and in the Common Benefit Identification Card Section of the EMEVS Provider Manual.

THE COMMON BENEFIT IDENTIFICATION CARD

There are four types of Benefit Identification Cards or documents: a photo card, a non-photo card, a paper replacement Common Benefit Identification Card and a Temporary Medicaid Authorization (DSS-2831A).

The photo and non-photo cards are permanent plastic cards and each contains information needed for eligibility verification for a single recipient. Each card contains the following information for the recipient: Medicaid number, first name, last name, middle initial, sex and date of birth. In addition, each card contains an access number, a sequence number, an

encoded magnetic stripe and a signature panel. The photo ID card also contains a photo and neither card contains an expiration date. The provider must verify recipient eligibility via EMEVS each time service is provided to be assured that a recipient is eligible.

The replacement Common Benefit Identification Card is a paper card and contains information needed for eligibility verification. This card contains the following information for the recipient: Medicaid number, name, sex and date of birth. In addition, the card contains an access number, a sequence number and an expiration date. As with the permanent plastic cards, the provider must verify recipient eligibility via EMEVS each time service is provided.

The Temporary Medicaid Authorization (DSS-2831A) is a paper document and contains information needed to bill MMIS for services rendered to the listed recipient(s). It is a guarantee of eligibility for the authorization period indicated (maximum 15 days); therefore, verification of eligibility via EMEVS 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 MMIS billing form in order to indicate that the recipient had a Temporary Medicaid Authorization. Please refer to the Billing Section of this manual for specific instructions.

RECIPIENT RESTRICTION PROGRAM (RRP)

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. State DSS and local social services districts may restrict recipients to the following provider types: physicians, clinics, pharmacies, 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 under the direction of non primary providers.

For additional information relating to the RRP, please consult the Policy and Billing Sections of this manual where specific guidelines for your provider types are outlined.

EMEVS

It is important for all providers to properly access EMEVS 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 EMEVS Provider Manual for instructions on EMEVS transactions.

2.1.2 Services Provided Under The Medicaid Program

General Description

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;
- 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 Plan);

- 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.

Note: Refer to Section 2.1.22 for an explanation of Utilization Thresholds and how they affect services under the Medicaid Program.

Individual providers should consult appropriate areas of the Guidelines Section for more specific information on services which they are authorized to provide under the Program, restrictions on those services, and policies on prior approval/authorization.

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.

CHILD/TEEN HEALTH PLAN (C/THP)

The Child/Teen Health Plan 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 C/THP 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.

C/THP 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.

QUALIFIED MEDICARE BENEFICIARY (QMB)

QMB benefits are limited to the payment of Medicare premiums, and the deductibles and coinsurance, as appropriate, for Medicare covered services.

2.1.3 Free Choice

General Policy

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, he/she 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 Section 2.1.20 of this Manual, "Civil Rights".

Guidelines

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.

2.1.4 Prior Approval

Definition

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 EMEVS). 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 the Inquiry Section of all Provider Manuals.

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. Subsequent sections of this Manual will specify prior approval requirements applicable to specific provider groups.

When a provider determines that a service requires prior approval, he/she must obtain a prior approval number by following the procedures outlined in this Manual. (Please refer to the Guidelines and Billing Sections of this Manual for additional information.) The Local Professional Director will review the proposed course of treatment and then submit his/her approval or disapproval to the State Department of Social Services and to the provider.

The State Department of Social Services will enter the information into the State Medicaid Management Information System 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 social services department or

the State Department of Social Services 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.

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 EMEVS BEFORE THE SERVICE IS PROVIDED.

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 by the Local Professional Director 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 social services department 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 form. (Please refer to the Billing Section of this 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.

2.1.5 Prior Authorization

Definition

Prior authorization is the acceptance by the local Commissioner of Social Services, or his/her designated representative, of 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 EMEVS BEFORE SERVICE IS PROVIDED.

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. The Guidelines Section of this manual specifies which services, if any, require prior authorization. Services requiring prior authorization are not subject to Utilization Thresholds.

2.1.6 Out-of-State Medical Care and Services

Enrollment of Out-of-State Providers

Out-of-State providers must enroll in the New York State Medicaid Program in order to be reimbursed by the program. (Please refer to the Inquiry Section for enrollment information.)

Description of Policy

Medicaid eligible individuals normally obtain medical care and services from qualified providers located in New York State. An 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 social services district 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 and Canada 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 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 NY 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 recipient's Local Professional Medicaid Director that care should be provided out-of-state. 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 outlined in the Billing Section of this manual.

2.1.7 General Exclusions From Coverage Under Medicaid Description Of Services For Which Medicaid Payment Is Not Allowed

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. The provider should refer to the Guidelines Section of this Policy Section for more specific information on restrictions applicable to care and services rendered.

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;
- When the claim is initially received by the Department more than ninety days after the original date of service (See Section 3.3, Field 39 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 Subsection 2.1.6;
- 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 EMEVS 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 billing form. Details are found in the Billing Section of this 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 are defined as 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 is that 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.

2.1.8 Confidentiality

General Policy

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 Department of Social Services, its various political subdivisions 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 State Department of Social Services which is under a very strict obligation to monitor medical practices under the Medicaid Program. Therefore, authorized representatives of the Department, its subdivisions 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.

2.1.9 Utilization of Insurance Benefits

Description of Policy

The Medicaid Program is designed to provide payment for medical care and services only after all other resources available for payment 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 social services department 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 obtained via EMEVS.

- **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 subsection 2.1.11.

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 Section of this manual. Specific information, if applicable, on the maximum utilization of Medicare benefits can be found in those sections of this Manual concerned with individual providers.

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 EMEVS. EMEVS 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 EMEVS response would be:

Medicare A HIC [12 digit #]

A recipient who has only Part B coverage, would have an EMEVS response:

Medicare B HIC [12 digit #]

The EMEVS 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 EMEVS.

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)**

  a. **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.

  b. **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.

  c. The availability of CHAMPUS/CHAMPVA medical coverage can be determined via EMEVS. The EMEVS response would be:

     54 [followed by up to 13 coverage codes]

     The provider will need to refer to pages 3-4 through 3-9 of this MMIS Provider Manual for the descriptions of these coverage codes.

- Insurance for Injuries Arising from Accidents

In such cases, medical payments may be available from Workers'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 social services department 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.

2.1.10 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. Specific criteria are found in the later sections of this manual. In order

to participate in the Medicaid Program, Providers are required to enroll with the State Department of Social Services.

(Please refer to the Inquiry Section of this Manual for information on obtaining enrollment forms.)

Providers must inform DSS 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.

2.1.11 Record-Keeping Requirements

General Description of Medicaid Policy

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 State Department of Social Services or the local social services department.

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.

2.1.12 Medical Review

General Policy

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 Medicaid Management Information System 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.

2.1.13 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. 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;
- 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 Medicaid Eligibility Terminal (MET) for verification, post and/or clear procedures when designated to do so.

Process for Resolving Unacceptable Practices
Notification
Proposed Action

If the Department proposes to sanction a person, the Department of Social Services 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.

Administrative Sanctions

When it is determined that a person has been engaged in unacceptable practices, the New York State Department of Social Services may take one or more of the following sanctions:

- The person may be excluded from participation in the Medicaid Program (refer to guidelines on p. 2-31). 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 Department of Social Services 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 New York Code of Rules and Regulations which are available in State and Court Libraries.

2.1.14 Audits

The Department of Social Services is responsible for monitoring the Medical Assistance Program in this 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.

2.1.15 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

Social Services 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 State Department of Social Services will receive reports of all proceedings.

2.1.16 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 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 my 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 available in State and Court Libraries.

2.1.17 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.

2.1.18 **Physically Handicapped Children's Program**

General Description of the 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 State Department of Health, 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 PHC Program, a child must first be determined to be medically eligible, e.g., to have one of the defects or disabilities referred to on pg. 2-38c. 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 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.

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 Common Benefit Identification Card is not sufficient authorization; its presentation by the client will not guarantee reimbursement. The verification process via EMEVS must be completed to determine the recipient's eligibility for Medicaid services and supplies.

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.

2.1.19 **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.

2.1.20 **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."

2.1.21 **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.

Family Care Program (continued)

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 that 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 New York State Department of Social Services' Division of Medical Assistance. Residents determined eligible for medical assistance are issued a permanent plastic Common Benefit Identification Card (DSS-3712).

2.1.22 Utilization Threshold Program Description

The Medical Assistance Program (Medicaid) 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

The Utilization Thresholds listed above have been set in accordance with recent historical information on service use from the Medicaid Management Information System (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 for those services that they provide. The Electronic Medicaid Eligibility Verification System (EMEVS) has been modified for this purpose.

The potential provider of a service will be required to access EMEVS either by the Medicaid Eligibility Terminal (MET), Verifone or telephone 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, EMEVS 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 form as described in the Billing Section of this 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 recipients's service limits. The provider will also be alerted to the fact that this letter has been sent via a message on the EMEVS 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 EMEVS terminal.

Certain Medicaid recipients will be exempt from 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 Plan services and kidney dialysis are among those included in this group.

Provider billing instructions are contained in the Billing Section of this manual.

2.2 PHARMACY GUIDELINES

2.2.1 Providers of Pharmaceuticals

Who May Dispense Drugs and Medical/Surgical Supplies

Drugs and medical/surgical supplies may be dispensed by pharmacies in New York State which are licensed and currently registered by the New York State Board of Pharmacy, Department of Education.

Drugs may also be provided by the prescribing practitioner. Medical/surgical supplies may also be provided by the prescribing practitioner, home health agencies, and medical/surgical supply dealers.

Who May Prescribe Drugs and Order Medical/Surgical Supplies

Both legend and non-legend drugs as well as medical and surgical supplies may be prescribed or ordered by physicians, podiatrists and dentists. Nurse Practitioners may prescribe the above within the scope of their practice. They currently may not prescribe for controlled substances.

Prescription and fiscal orders may also be written by a registered physician's assistant when assigned by the supervising physician. Except for controlled substances as listed under Federal and State Controlled Substances Acts, a registered physician's assistant may write prescriptions and fiscal orders for a recipient who is under the care of the physician responsible for the supervision of the registered physician's assistant.

Prescriptions/orders from a physician's assistant must be written on the blank of the supervising physician and shall include the name, address, and telephone number of the physician. The prescription/order shall also bear the name, the address, the age of the recipient, and the date on which the prescription/order was written.

The registered physician's assistant shall sign such a prescription/order by printing his/her name followed by the letters R.P.A. and his/her registration number. The registered physician's assistant must also include on the prescription/order form the physician's license number and all other information required of the physician except the physician's signature.

Certified nurse practitioners may also write prescription and fiscal orders for recipients within the Medicaid program under the following guidelines:

- Any certified nurse practitioner may write a fiscal order for non-legend drugs and non-legend medical and surgical supplies.
- Certified nurse practitioners who have completed instruction in New York State and Federal laws and regulation relating to prescriptions and record keeping may write prescriptions for legend and non-legend drugs, legend and non-legend medical and surgical supplies. Such certified nurse practitioners are identified by a six digit license number proceeded by an F.
- Certified nurse practitioners may not write prescriptions for controlled substances as listed under Federal and State Controlled Substances Acts.

2.2.2 Definitions

The following terms are defined for the purposes of Medicaid and are included to help clarify pricing policies:

Compounded Prescription is one in which two or more ingredients are mixed by the dispensing pharmacist.

In order to qualify for Medicaid payment a compounded prescription must include:

a. a combination of any 2 or more legend drugs found on the list of Medicaid Reimbursable Prescription Drugs: or

b. a combination of any legend drugs included on the list of Medicaid Reimbursable Prescription Drugs and any other item(s) not commercially available as an ethical or proprietary product(s); or

c. a combination of 2 or more products which are labeled "Caution: For Manufacturing Purposes Only."

The reconstitution of a commercially available drug is NOT regarded as a compounding procedure.

Dose is the exact amount of medicine to be taken at one time or at stated intervals according to the prescriber's directions.

Estimated Acquisition Cost (EAC) is the closest approximation of the acquisition or invoice cost of the most commonly stocked package size at which the majority of pharmacy providers purchase the drug product. The EAC price for all prescribed drugs is computed by the State.

Fiscal Order is written by a physician, dentist, podiatrist, physician's assistant, or nurse practitioner to provide supplies or over-the-counter drugs for which prescriptions are not required by law or regulation. The prescriber may use his/her prescription blanks to write fiscal orders.

Formulator, is the company that fabricates a tablet, capsule, suppository, etc., containing the active ingredient of a drug plus inert ingredients, and markets these products under its label.

Generic Category, is a group of drug products with the same active chemical ingredients and the same established, official chemical name, irrespective of manufacturer.

Labeler, is a company which buys drugs in bulk, repackages and sells the drug under its own or another firm's label.

Medical and Surgical Supplies, are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment which have been ordered by a physician, dentist, podiatrist, physician's assistant, or nurse practitioner in the treatment of a specific medical condition and which are consumable, non-reusable, disposable, for a specific rather than incidental purpose, and generally have no salvageable value. Some medical/surgical supplies require a prescription under New York State Law.

Some examples of medical or surgical supplies are bandages, gauze pads, colostomy bags, catheters and irrigating kits, family planning devices, etc.

Medical/surgical supplies do not include items and supplies that are useful to persons in the absence of an illness or injury or that are primarily used to service needs other than health needs. Examples of consumable and non-reusable supplies that are not included under Medicaid are items of personal hygiene (soap, shampoo, etc.); feminine hygiene items (sanitary belts, sprays, etc.); and dental hygiene items (toothbrush, dentifrice, mouthwash, etc.).

Multiple Source Drug, is a drug marketed or sold by two or more formulators or labelers or sold by the same formulator or labeler under two or more different brand names.

New York State List Of Medicaid Reimbursable Drugs:
Non-Prescription Drugs and Prescription Drugs,
includes those non-prescription (OTC) drugs and those generic and brand-name prescription drugs for which Medicaid will reimburse the provider. The statutory authority for the List is found in Chapter 76 of the Laws of 1976 and in Chapter 77 of the Laws of 1977; regulatory authority can be found in 10 NYCRR 85.21 and 85.25.

Non-Prescription Drug, also called a non-legend or over-the-counter (OTC) drug, is a drug for which no prescription is required by law or regulation.

Package or Unit Size, of non-prescription drugs is the retail package closest in quantity to the amount prescribed.

Prescribing Practitioner, is a physician, (MD, DO) dentist, podiatrist, physician's assistant, or nurse practitioner licensed by law and currently registered to prescribe and administer prescription drugs. Interns and residents may prescribe and administer prescription drugs (under the supervision of a licensed physician or dentist) as part of their official duties as members of a hospital staff.

Prescription Drug, defined by the Federal Government as a legend drug or a drug without a Federally required legend but under New York State Law treated as a legend drug, is a drug for which a prescription from a qualified, licensed practitioner is required under Section 6810 of the Education Law. These drugs are subject to the requirements of the Federal Food, Drug and Cosmetic Act and those stipulated by the State Commissioner of Health. All controlled substances are prescription drugs.

Single Source Drug is a drug produced by a single manufacturer and protected by a patent for a period of up to 17 years. There are no generic equivalents for single source drugs.

Usual and Customary Charge is the price which a pharmacy charges to the "general public." The general public is defined as the group accounting for the largest number of non-Medicaid transactions from the individual pharmacy and does not include other third party payors.

2.2.3 Scope of Pharmaceutical Services

General Policy

Drugs

The New York State List of Medicaid Reimbursable Drugs: Non-Prescription Drugs and Prescription Drugs has been established by the New York State Commissioner of Health.

Only those prescription drugs which appear on the List are eligible for Federal and State financial participation under Medicaid and, thus, are reimbursable under the New York State Medicaid Program. The Prescription portion of the List contains both generic and brand name prescription drugs and is indexed alphabetically by drug name, strength, and unit. Please note that if a brand name drug prescribed "dispense as written" does not appear on the List by the same brand name, but rather appears by its chemical (generic) name and/or under a different brand name, this drug is reimbursable under Medicaid.

Only those non-prescription drugs which appear on the List are eligible for Federal and State financial participation under Medicaid and, thus, are reimbursable by the New York State Medicaid Program. The List contains

those non-prescription therapeutic categories which the Commissioner of Health has specified as essential in meeting the medical needs of recipients. The Non-Prescription portion of the List does not use specific brand names. It is indexed alphabetically by generic and therapeutic category.

Please note that drugs which are not on the List may be provided to recipients by a facility (e.g., a hospital, residential health care facility) which includes the cost of drugs in its Medicaid rate. All drugs which comprise the facility's pharmacy formulary are covered in the rate and cannot be billed for separately.

Pharmacists may wish to display in their stores a notice to recipients explaining that Medicaid does not cover all drugs. A notice, suitable for copying and display, has been included at the end of this Policy Section.

The List of Medicaid Reimbursable Drugs will be amended as necessary, by the State Commissioner of Health.

Medical/Surgical Supplies

Prescribers may order supplies which are contained on the list of Allowable Medical and Surgical Supplies. If the supply does not appear on the list, the pharmacist may request the supply through the prior approval process.

The list of Allowable Medical and Surgical Supplies will be amended, as necessary, by the New York State Commissioner of Health.

Standards of Quality

Standards for the quality of drugs provided under Medicaid must conform with standards in the United States Pharmacopeia and National Formulary where applicable. All drugs dispensed shall be those of reputable manufacturers (i.e., manufacturers of proven integrity and dependability). They should be distributed by marketers with approved New Drug Applications or Abbreviated New Drug Applications on file with the Food and Drug Administration.

In accordance with Section 6808 of the State Education Pharmacy Law, pharmacists are responsible for the strength, quality, and purity of the drugs they dispense.

Prescribing and Dispensing Limitations

Medicaid reimbursement will NOT be provided for the following:

- amphetamine and amphetamine-like drugs which are used for the treatment of obesity;
- drugs whose sole clinical use is the reduction of weight;
- any drug regularly supplied to the general public free of charge must also be provided free of charge to Medicaid recipients;
- any controlled substance stamped or preprinted on a prescription blank;
- any drug not included on the New York State List of Medicaid Reimbursable Drugs: Non-Prescription and Prescription Drugs unless provided by a facility which includes the cost of drugs in its rate;
- any item marked "sample" or "not for sale";
- any contrast agents, used for radiological testing (these are included in the radiologist's fee) except for Iopanoic Acid;
- any legend drug which does not have a National Drug Code;
- drugs packaged in unit doses.

Dispensing Limitations for Items Provided by Residential Health Care Facilities

Effective January 1, 1979, all New York State residential health care facilities have included in their Medicaid rates prescription and non-prescription drugs and medical/surgical supplies. Residential health care facilities may: (1) operate an institutional pharmacy to provide these items and (2) contract with a community pharmacy to provide these items to its Medicaid residents. In the second instance, the pharmacy must be reimbursed by the facility for these items.

However, out-of-state residential health care facilities may or may not include prescription and/or non-prescription drugs and medical/surgical supplies in their rates.

Those items not covered in the facility's Medicaid rate may be provided by a community pharmacy, which in turn may bill New York State Medicaid for those items.

Residential health care facilities with inclusive Medicaid rates for drugs and supplies may dispense these items to their Medicaid residents regardless of the refill, quantity, and prior approval limitations described in this Manual.

Recipient Restriction Program (RRP)

Recipients who have been assigned to a designated pharmacy are required to receive all pharmacy services from the selected provider. All claims from other pharmacies will be denied. Recipients who are restricted to a primary DME dealer must receive all durable medical equipment and prosthetic and orthotic appliances from that provider.

All primary pharmacy providers must maintain a patient profile for each restricted recipient. The profile must contain, at a minimum , the name, and the date the drugs or supplies were dispensed. These profiles must be made readily available to DSS or its agents upon request.

RRP: Ordered Services

When a recipient is restricted to an ordering provider (physician, clinic, podiatrist and/or dentist), all pharmacy services must be ordered by the primary provider within the recipient's restriction type. The primary provider may refer the restricted recipient to another provider and that servicing provider may also order services. In either case, the primary provider's MMIS identification number must be written on the order/prescription form and should be used by the dispensing pharmacy when accessing the EMEVS system as well as when submitting claims.

2.2.4 Quantity and Refill Policy

A pharmacist may not fill an original prescription or fiscal order more than 14 days after it has been initiated by the prescriber.

Original Prescription (Legend) Drug Orders

Prescribed quantities for legend drugs shall be dispensed in the amount prescribed, taking into consideration the following limitations.

Drugs and medical/surgical supplies should be ordered in sufficient quantity consistent with the health needs of the recipient and sound medical practice. If the prescription is not for a long-term maintenance drug, as defined below, the maximum quantity of a drug that shall be dispensed is limited to the larger of a 30 day supply or one hundred doses. One hundred doses is 100 units of a solid formulation. Other medication formulations shall be dispensed in a maximum of a 30 day supply.

For Medicaid purposes, long-term maintenance drugs are identified as those drugs considered by the New York State department of Social Services to be:

- Anticonvulsants
- Antidiabetics
- Antifungal agents
- Cardiac drugs
- Hormones
- Hypotensive (Antihypertensive) agents
- Thyroid preparations
- Diuretics
- Antihyperlipidemics
- Anticholinergic and parasympatholytic agents for treatment of ulcers (histamine H 2 receptor antagonists are not included)
- Prescriptions written and dispensed on the Official New York State Triplicate Prescription form for up to a "three month supply" when written in conformance with the Controlled Substances Act (Title IV of Article 33 of the Public Health Law).

Pharmacies are currently required to include the days supply and quantity dispensed information on the claim submitted to Medicaid for payment. It may be necessary for a pharmacist to be sure that the prescription can support the dosage requirements for audit purposes.

Original Non-Prescription (OTC) Drug and Medical Supply Orders

Non-prescription drugs and medical supplies can only be obtained by presenting a signed written order from a qualified prescriber. This written direction is considered to be a fiscal order rather than a prescription.

For these non-prescription drugs, and medical supplies if the ordering practitioner does not request a quantity that corresponds

to the pre-packaged unit, the pharmacist should supply the drug or medical supply in the pre-packaged quantity that most closely approximates the amount ordered.

A maximum quantity of five units may be ordered for non-prescription drugs and supplies or the quantity indicated in Section 4.3 Medical/Surgical Supplies without prior approval. If the fiscal order exceeds this amount, the pharmacist must obtain prior approval.

Refills

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

For supplies, prescription and non-prescription drugs, a maximum of 5 refills is permitted by Medicaid unless otherwise indicated.

No prescription or fiscal order for a drug or supply may be refilled 180 days from the original date ordered.

All refills of prescription drugs must bear the prescription number of the original prescription. Refills of over-the-counter drugs and medical/surgical supplies must also be appropriately referenced to the original order by the pharmacist.

Reimbursement will not be available for refills for Schedule II Controlled Substances, which cannot be refilled under the Federal and State Controlled Substances Acts.

2.2.5 A. Prior Approval

Prior Approval Obtained by the Prescriber

The prescriber must obtain a prior approval number from the Local Professional Director before initiating certain prescriptions and fiscal orders as listed below. If the prior approval number does not appear on the prescription or order form, the pharmacist will not be able to properly complete the claim and thus will not be reimbursed for the drug. In the event a prescription or order has been telephoned to the pharmacy, the pharmacist must obtain the prior approval number from the prescriber at the time of that telephone call. For further information pertaining to prior approvals, refer to the Billing and Inquiry Sections of this Manual.

The prescriber must obtain a prior approval number before writing prescriptions and fiscal orders for enteral formaulae and certain parenteral formulae. Please refer to the New York State fee schedule. Underlined code numbers found in the fee schedule indicate those items which require prior approval.

Prior Approval Obtained by the Pharmacist

The pharmacist must obtain a prior approval number before dispensing the following:

- Any non-prescription drug or medical/surgical supply ordered in quantities larger than five units or the quantity indicated in Section 4.3 Medical/Surgical Supply of this Manual;

- Any medical/surgical supply not on the list of allowable Medical and Surgical supplies or for which a "general header code" is used.

If a prescription or order which requires prior approval is filled by the pharmacist at a time when the pharmacist cannot obtain a prior approval number, e.g., weekends, nights, holidays, the pharmacist will risk not being paid for that prescription or order. The pharmacist must call for a prior approval number on the next working day after the prescription or order was filled.

For instructions concerning how to obtain a prior approval number, refer to Section 3.6 of this Manual.

B. Prior Authorization

Prior Authorization must be obtained from the New York State Department of Social Services before selected items of medical/surgical supplies are dispensed. Items which require prior authorization are indicated by a "+" following the code number in the O.T.C./Supply Code Section of this manual. Instructions for obtaining prior authorization can be found in the Billing Section of this manual.

C. Service Limits

Selected items of medical/surgical supplies now have fixed limits in the amount and frequency that can be dispensed to an eligible recipient. These limited items require prior authorization as referenced in Section B. Recipient utilization is monitored through the prior authorization process to ensure that the limits are not exceeded by the recipient. If a recipient has exceeded the limit on an item, prior authorization will not be issued.

The following items are limited in amount and frequency:

Item	Limit
E0100 Cane	1 every 3 yrs.
E0105 Cane, Quad or three prong	1 every 3 yrs.
A4500 Surgical stocking/below knee	4 pair per yr.
A4495 Surgical stocking/thigh length	4 pair per yr.
A4510 Surgical stocking/full length	4 pair per yr.
E0276 Bed pan, fracture	1 every 3 yrs.
Z4359 Urinary suspensory	1 every 5 yrs.
Z2142 Emesis basin	1 every 5 yrs.
E0160 Sitz bath	1 every 5 yrs.
E0326 Urinal, female, any material	1 every 5 yrs.
E0325 Urinal, male, any material	1 every 5 yrs.
E0167 Commode pail	1 every 5 yrs.
Z2623 Humidifier, cold air	1 every 3 yrs.
E0605 Vaporizer, room type	1 every 3 yrs.
E0210 Electric heating pad, standard	1 every 3 yrs.
Z2304 Hot fomentation heating pads	1 every 3 yrs.

D. Utilization Threshold

As of October 1, 1989, under the Utilization Thresholds Program, it will be necessary for providers to obtain an authorization from EMEVS to render services for physician, clinic, laboratory, pharmacy, podiatric and dental care. This authorization to render services will be given unless a recipient has reached his/her utilization threshold limits. At this point, it will be necessary for an ordering provider to submit a special "Application For Changing Limits" form in order to obtain additional service authorizations. In certain special circumstances, such as emergencies, providers do not have to receive authorization from EMEVS. See special instructions in the Billing Section of this manual. Arrangements have also been made to permit a provider to request a service authorization on a retroactive basis. In requesting a retroactive service authorization you risk your request being denied if the recipient has reached his/her limit in the interim. After you receive an authorization your claim may be submitted to our Fiscal Agent for processing. The regulation requiring claims to be submitted within 90 days of the date of service still applies.

- Laboratories and pharmacies may not submit a request for an increase in laboratory or pharmacy services. Such requests are to be submitted by the ordering provider. Laboratories which need to determine whether tests are needed on an emergency or urgent basis (see page 2-20 for definitions) shall consult with the ordering provider, unless the order form indicates that an urgent or emergency situation exists.

- Those limited laboratory services which can be rendered by a physician or podiatrist in private practice to his/her own patients do not count toward the laboratory utilization threshold.

- Utilization Thresholds will not apply to services otherwise subject to thresholds when provided as follows:

(a) "managed care services" furnished by or through a managed care program, such as a health maintenance organization, preferred provider plan, physician case management program or other managed medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program;

(b) services otherwise subject to prior approval or prior authorization;

(c) reproductive health and family planning services, including: diagnosis, treatment, drugs, supplies and related counseling furnished or prescribed by or under the supervision of a physician for the purposes of contraception, sterilization or the promotion of fertility. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease and pregnancy and pelvic abnormalities;

(d) Child/Teen Health Plan services;

(e) services provided by or under the direction of a primary provider under the Recipient Restriction Program;

(f) methadone maintenance treatment services;

(g) services provided by private practitioners, with the exception of podiatrists, on a fee-for-service basis to inpatients in general hospitals and residential health care facilities;

(h) hemodialysis services;

(i) school health project services; and

(j) obstetrical services provided by a physician, hospital outpatient department, or free-standing diagnostic and treatment center.

- The numbers of visits, lab procedures, medical supplies, drugs, and other items for each provider type are found in the General Policy Section 2.1.22 of this manual.

POST AND CLEAR

Certain providers, designated by the Department, must use the Electronic Medical Eligibility Verification System (EMEVS) to verify eligibility for all Medicaid recipients.

These providers are required to use the Medicaid Eligibility Terminal (MET) to verify eligibility by "swiping" the plastic identification card through the terminal in a substantial number of cases.

Certain providers who are able to order medical care, services or supplies, may be designated by the Department to enter, via EMEVS using a MET the number of pharmacy prescriptions and laboratory tests ordered.

Orders entered by these providers will have to be "cleared" off of EMEVS by the laboratory or pharmacy rendering the service.

These procedures are operational through use of the Electronic Medicaid Eligibility Verification System (EMEVS) which allows direct access to the Medical Assistance database via either telephone or a Medicaid Eligibility Terminal (MET).

2.2.6 Record-keeping Requirements

General Requirements

In addition to meeting the general record-keeping requirements outlined in the General Policy Section 2.1.11 of this Manual, pharmacies must keep on file the signed prescription or fiscal order of the prescribing physician, dentist, podiatrist, physician's assistant, or nurse practitioner for any drugs (including over-the-counter drugs) and supplies for which Medicaid payment is claimed. For audit purposes, these signed prescriptions and fiscal orders must be kept on file for six years.

Telephone Prescriptions

Effective April 1, 1981, prescribing practitioners may telephone prescriptions for Medicaid recipients directly to a pharmacy unless otherwise prohibited by State or Federal Law or Regulations. Refills of such telephoned orders are not permitted unless the original telephoned prescription is supported by a signed written order of the prescriber. (Note that this does not apply to fiscal orders for which only written orders are permitted.)

A telephoned order must be reduced to writing indicating the time of the call and initials of the dispenser. Additionally, a format used to record the telephoned order must conform to requirements of the State Education Law with regard to permitting substitution or dispensing as ordered. A telephone prescription for a brand name drug which requires that "brand necessary or brand medically necessary" be handwritten by the prescriber on the prescription, must be followed with a written prescription within 5 business days.

Prescriptions for multi-source brand drugs requiring "brand necessary" or "brand medically necessary" may be ordered over the telephone. When a pharmacy obtains this prescription over the telephone, it is the responsibility of ordering prescribers to send pharmacists written prescriptions for brand name multi-source drugs when they want brand name drugs. (The pharmacist is required to have this prescription with the required information on file within 5 business days of the telephone call.)

Patient Profiles

In accordance with Chapter 770 and 771 of the New York State Laws of 1977, pharmacies operating in Shared Health Facilities must maintain records of all medications prescribed by any practitioner, plus the precise dosage and prescription regimens for each medication.

2.2.7 Application of Free Choice

Ambulatory Patients

The choice of which pharmacy will fill his/her prescription/ order rests with the recipient, unless a recipient has been restricted by Medicaid to a primary pharmacy. Except for telephone prescriptions, the prescribing practitioner should give the written prescription/order to the recipient in order to allow the recipient to exercise his/her freedom of choice. This principle also applies to recipients ill in their homes.

It is understood that recipients using clinics which include pharmacy items in their rates have, in making the choice of the facility, also chosen the pharmacy.

Inpatients

It is understood that recipients in hospitals, skilled nursing facilities, or health related facilities which operate institutional pharmacies or which have a contract with a pharmacy to supply the pharmacy items in their all-inclusive rates have, in making the choice of facility, also chosen the pharmacy.

2.2.8 Generic Drug Substitution Policy

It is anticipated that Medicaid participating pharmacists will comply with all State requirements adopted pursuant to New York State drug substitution laws.

2.2.9 Monitoring

Federal regulations require that pharmacy providers be monitored in order to assure that reimbursement for drugs is made at the lowest possible level, consistent with accurate cost information. This monitoring will consist of on-site reviews to verify that the pharmacy is submitting its usual and customary price to the general public (refer to the General Information Section 2.1.12 of this Manual for further information).

2.2.10 Out-of-State Pharmacy Providers

General Policy

Out-of-state pharmacies, which provide drugs to New York State Medicaid recipients, must be properly registered and/or licensed by the appropriate authority in the state in which the pharmacy is located.

Prescriptions and fiscal orders may be filled by out-of-state pharmacies in the "common medical marketing area" of the recipient's local social services district. That common medical marketing area is defined by the Local

Professional Director. Pharmacies determined to be in the common medical marketing area will be held to the policies in this Manual unless those policies conflict with their state's laws.

Prescriptions and fiscal orders may be filled by an out-of-state pharmacy which is not in a recipient's "common medical marketing area." Before filling a prescription or fiscal order, however, the pharmacy must obtain prior approval from the Local Professional Director in New York State; this prior approval requirement can only be waived when a drug or supply is dispensed in an emergency. The out-of-state pharmacy must also comply with the policies outlined in this Manual unless those policies conflict with its state's laws.

Generic Substitution

While out-of-state pharmacies are bound to their state's generic substitution laws, New York State will reimburse such pharmacies at levels consistent with the New York State generic substitution policy.

2.2.11 BASIS OF PAYMENT

Prescription and Non-Prescription Drugs

Reimbursement for each covered prescription drug is restricted to the lower of;

- The usual and customary price charged to the general public; or

- The State Estimated Acquisition Cost (EAC) plus a dispensing fee of $2.60;

Reimbursement for each covered non-prescription drug is restricted to the lower of;

- The usual and customary price charged to the general public on the date of provision of service, not to exceed the lower sale price, if any, in effect on that date; or

- The price established by the Commissioner of Health as shown on the New York State List of Medicaid Reimbursable Drugs for that generic category and strength in the package size nearest to that ordered.

Please note, however, that when the cost of drugs is included in a facility's Medicaid rate, the EAC and usual and customary pricing policies do not apply.

Compounded Drugs

For a compounded prescription, an additional $.75 will be added to the $2.60 dispensing fee plus cost of the ingredients. This fee, however, will not be paid when a pharmacist reconstitutes a manufacturer's specialty or adds a non-medical or non-therapeutic agent.

Multiple Source Drugs

Reimbursement is only available to the pharmacy for those multiple source drugs contained on the drug microfiche (see Section 2.2.12) or hard copy of the microfiche.

Brand Medically Necessary Override:

A pharmacist shall substitute a generic drug when listed in the Health Department publication - "Safe, Effective and Therapeutically Equivalent Prescription Drugs - (whenever available) unless the prescriber writes "daw" (dispense as written) on the prescription form. However, for certain brand name Medicaid prescriptions to be eligible for reimbursement of the EAC price, prescribers must also certify that they require the brand name drug by writing directly on the face of the prescription "brand necessary" or "brand medically necessary" in their own handwriting. A rubber stamp or other mechanical signature device may not be used. The pharmacist may then indicate a "yes" in the brand necessary field (field 26) of the claim form which will cause the claim to be paid at the EAC price.

A prescription for the brand name drugs requiring "brand necessary" or "brand medically necessary" ordered by telephone must be followed with a written prescription within 5 business days.

The drugs currently subject to the physicians override provision will have two filled price field on the monthly fiche sent to pharmacies. The two fields are the **MRA COST** and **COST ALTERNATE**. The **COST ALTERNATE** is the override price. If the **COST ALTERNATE** field is blank, the medication is not currently affected by the physicians override provision in the New York State Medicaid program.

Medical and Surgical Supplies

Reimbursement for each covered medical/surgical supply will be the lower of:

- The price as indicated on the New York State List of Medical/Surgical Supplies; or
- The usual and customary price charged to the general public.

"Covered Supplies" are those on the list of Allowable Medical and Surgical Supplies found in Section 4.0 of this Manual. For supplies not on that list, only those supplies for which the pharmacist has obtained prior approval are covered.

Please note that the general "header codes" on the list of Allowable Medical and Surgical Supplies cannot be used for billing Medicaid without prior approval.

Medicaid/Medicare Reimbursement

Medicare does not provide coverage of drug items as part of outpatient services. For persons who are covered under Medicaid as well as Medicare, Medicaid will pay for the outpatient pharmacy services for which Medicare will not provide reimbursement.

For reimbursement, outpatient pharmacies should submit their claims using their usual and customary drug charge.

Since Medicare will provide reimbursement for the clinic visit, it is appropriate for the outpatient pharmacy to bill Medicaid only for the drug(s) provided.

For a service with both Medicare and Medicaid coverage, all charges for services must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOMB) form is received from the Medicare intermediary, may a claim be submitted for Medicaid reimbursement. The pharmacist must maintain the EOMB on file for six years following the date of payment for audit purposes.

Medicaid will not pay for Medicare coinsurance and deductible for Medicare - covered supplies provided to Medicaid recipients who are also Medicare beneficiaries when the Medicare payment

exceeds the Medicaid fee or rate. The Medicare payment will be considered payment in full by the Medicaid program and no additional payment will be made for the service. When the Medicare payment is less than the Medicaid fee or rate, Medicaid will pay the difference between the Medicare Approved Amount or the Medicaid rate or fee. When a procedure requires prior approval, prior approval must be obtained by the provider when a recipient has both Medicare and Medicaid coverage in order to receive Medicaid payment for Medicare deductibles and coinsurance.

Outpatient Clinics

Since community pharmacists may not know whether a clinic has drugs included in its Medicaid rate, pharmacists may fill and receive Medicaid payment for prescriptions originating in clinics provided all other Medicaid requirements (e.g., prior approval, recipient eligibility) are met.

2.2.12 Explanation of Pharmacy Microfiche

The New York State microfiche of reimbursable drugs and supplies contains a list of all Medicaid reimbursable drugs with unit prices and a list of reimbursable medical/surgical supplies for the month. When reading the microfiche, pharmacists should be aware that:

1. An asterisk (*) following an entry indicates that some change has been made to this listed item since publication of the previous list;

2. Under "Prior Approval Code Indicator (PA CD)," a zero (0) indicates that no prior approval is required for the corresponding item; any other numeric value (1,2, or 3) in this field indicates that prior approval must be obtained before the drug/supply can be dispensed;

3. Product descriptions may vary in word order e.g., SOD SULFACETAMIDE OPH SOL or SULFACETAMIDE SOD OPH SOL;

4. Hyphenated words alter the alphabetic sequence in the list e.g., THEO-DUR is listed before THEOBID;

5. OTC, supply and compounded prescription items are found at the end of the list;

6. The "Index Key," an index to items on a single sheet of microfiche film, appears in the last position on each sheet of film.

7. Cost alternate field - Field used to identify the EAC price for those brand name multi-source drugs affected by the brand name medically necessary override provision.

NOTE: If you have a question regarding an NDC number or price of a legend drug on the State Microfiche, consult page 5-7, Inquiry, of this Manual for the appropriate name and phone number to call.

2.2.13 Certification

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 therefor shall be promptly furnished upon request to the local or State Departments of Social Services, 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 (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 New York State Department of Social Services 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 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.

2.2.14 Drug Utilization Review Programs

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

The benefits of DUR programs are reduced Medicaid costs, reduced hospital admissions, improved health for Medicaid recipients, and increased coordination of health care services.

The Federal legislation requiring states to implement DUR programs also requires states to establish DUR Boards whose function is to play a major role in each state's DUR program. The Department of Social Services has established a DUR Board comprised of health care professionals with recognized knowledge and expertise. The Board consists of five physicians, five pharmacists, two person with expertise in drug utilization review and one designee of the Commissioner of Social Services.

The two components of New York State's DUR program are Retrospective DUR (RetroDUR) and Prospective DUR (ProDUR). While the two programs work cooperatively, each seeks to achieve better patient care through different mechanisms. Each of these programs is described in detail below.

RetroDUR

The Department of Social Services implemented a RetroDUR program as of January 1, 1993. The RetroDUR program is designed to educate physicians by targeting prescribing patterns which need to be improved. Under RetroDUR, a review is performed subsequent to the dispensing of the medication, while ProDUR requires a review to be done prior to dispensing the prescription.

The primary goal of RetroDUR is to educate physicians through alert letters which are sent to practitioners detailing potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy interactions and clinical abuse/misuse. It is expected that physicians who receive alert letters identifying a potential problem relating to prescription drugs will take the appropriate corrective action to resolve the problem.

ProDUR

As of January 1, 1993 Medicaid enrolled pharmacies were required to perform in-house prospective drug utilization review. On June 1, 1994 the Department of Social Services implemented a ProDUR program through the Electronic Medicaid Eligibility Verification System (EMEVS). The point-of-sale system allows pharmacists to perform on-line, real-time eligibility verifications, Electronic Claims Capture (ECC) and offers protection to Medicaid recipients in the form of point-of-sale prevention against drug-induced illnesses.

The ProDUR/ECC system maintains an on-line record of every Medicaid recipient's drug history for at least a 90 day period. The pharmacist enters information regarding each prescription and that information is automatically compared against previously dispensed drugs, checking for any duplicate prescriptions, drug to drug contraindications, over and under dosage and drug to disease alerts, among other checks. In the event that this verification process detects a potential problem, the pharmacist will receive an on-line warning or rejection message. The pharmacist can then take the appropriate action; for example, contacting the prescribing physician to discuss the matter. The outcome might be not dispensing the drug, reducing the dosage, or changing to a different medication.

The ProDUR Program is administered by the Department's EMEVS contractor. Use of the on-line DUR functions via EMEVS by pharmacy providers is mandatory. This includes all non rate-based pharmacy providers. Pharmacy providers are required to use personal computers or central processing units to access EMEVS, either independently or through a switch company. The card swipe program is still required when a provider is so designated by the Office of Quality Assurance and Audit (QAA). Any data entered by the pharmacy provider continues to first be processed by EMEVS, including checking eligibility, third party coverage, Utilization Threshold, Post and Clear and Recipient Restriction Program status before being passed to the DUR system. The DUR system utilizes National Council on Prescription Drug Program (NCPDP) format version 3.2. NCPDP responses alert providers to the type of drug interaction, drug-disease conflict, therapeutic duplication or overutilization problems, and the most recent fill dates for the potentially hazardous drug. A maximum of three different codes/drug interactions per prescription per entry may be sequentially displayed for up to four prescriptions per entry. All of the DUR messages are specified by the State DUR Board which is composed of doctors, pharmacists, and DUR experts in concert with First Data Bank's criteria levels.

ProDUR Claims Submission

Pharmacy providers can also submit most of their claims directly via the electronic claims capture module that was developed for the ProDUR system. Once the data required for eligibility verification and claiming has been processed for EMEVS and ProDUR purposes, the pharmacist is given the option of submitting the claim to MMIS directly with no further paper or magnetic media necessary, if the claim capture option was selected for that claim. Compound drugs, durable medical equipment, and other select drug claims cannot be billed yet via ECC.

Certification for ProDUR/ECC

All Medicaid pharmacy providers are required to perform on-line prospective drug utilization review. Submitting claims via ECC is optional. Under ProDUR, all pharmacies must enter their transaction using the NCPDP formats via one of the EMEVS access methods listed below.

The only access to EMEVS allowed for ProDUR/ECC is via a PC-host (Personal Computer) or CPU-CPU (Central Processing Unit) connection, either directly to the EMEVS contractor or through a switching company. All of the following steps must be completed by pharmacies for ProDUR/ECC preparation.

- Select an EMEVS access method from the following:
  - PC-Host to Deluxe Data Systems (EMEVS Contractor) - Independent
  - CPU-CPU to Deluxe Data Systems (EMEVS Contractor) - Independent
  - PC-Host via a switch company to Deluxe Data (EMEVS Contractor)
  - CPU-CPU via a switch company to Deluxe Data (EMEVS Contractor)
- Complete and mail an Alternate Access Request form to the EMEVS Contractor:

  Deluxe Data Systems, Inc.
  400 West Deluxe Parkway
  Milwaukee, WI 53212
  Attention: Diane DeGrand
  Phone Number: 1-800-343-9000

- If you plan to use the optional ECC feature:
  - Select a PIN # (Personal Identification Number). Complete and return the PIN Selection Form to the NYS Department of Social Services.

- If you do not already have one, obtain a Tape Supplier Number (TSN) (also known as a Magnetic Input Supplier Number) from Computer Sciences Corporation (CSC). CSC can be contacted by calling (518) 447-9256.

- Once you have been assigned a TSN, complete, sign and have notarized the MMIS Certification Statement for Provider Utilizing Electronic Billing and return to CSC at the following address:

  Computer Sciences Corporation
  800 North Pearl Street
  Albany, NY 12204
  Attention: Magnetic Media Unit - 1st Floor

Please note that the pharmacy's MMIS provider identification number must be indicated on both the Alternate Access Selection Form and the Certification Statement.

If your selected access method is an independent PC-Host or CPU connection to Deluxe Data Systems, the following points apply to you:

- Deluxe Data will send you an Alternate Access Agreement contract along with the NCPDP format specifications and telecommunication specifications.
- The Alternate Access Contract must be signed and returned to Deluxe Data with a check for the fee for certification, testing, etc.
- If you are not programming your own software, you should contact a software company. The NYS/DSS has issued the ProDUR/ECC NCPDP format specifications to numerous software companies located both in and out of New York State.

- Send Alternate Access Agreement Contract to:

Deluxe Data Systems
400 West Deluxe Parkway
Milwaukee, WI 53212
Attention: Diane DeGrand
Phone Number: 1-800-343-9000

If your selected access method is through a switch, the following points apply to you:

- You can only use a switch company that is enrolled with MMIS as a service bureau. Please verify with your switch company that they meet this requirement.
- Contact the switch company to become acquainted with their operation. Each company has their own procedures and costs and will advise pharmacies accordingly.
- Verify that the switch company has sent Deluxe Data Systems an approval letter or memo advising them that your pharmacy has contracted with the company for your pharmacy's DUR transactions. Your MMIS provider number and pharmacy name must be indicated on their letter and/or memo. Deluxe Data Systems cannot authorize alternate access unless they have written notification and approval from both the pharmacy and the switch company.
- The switch company must sign a contract with Deluxe Data Systems.
- Your switch company should be able to provide you with the most current copy of the DUR/ECC NCPDP format specifications.
- Questions regarding DUR/ECC program policy should be directed to the Division of Health & Long Term Care at (518) 474-6866.
- Technical questions regarding Alternate Access methods should be directed to Deluxe Data Systems at 1-800-343-9000.

If you are unable to obtain a copy of the NCPDP format specifications from your software or switch company, call Deluxe Data Systems for a copy.

PLEASE CONSULT THE EMEVS DUR USER MANUAL FOR SPECIFIC INFORMATION RELATING TO PRODUR, ELECTRONIC CLAIMS SUBMISSION, AND EMEVS ACCESS METHODS.

BILLING

NOTICE TO MEDICAID CLIENTS

CONCERNING

DRUG COVERAGE

NEW YORK STATE MEDICAID PAYS ONLY FOR THOSE DRUGS APPROVED BY THE STATE DEPARTMENT OF HEALTH. IF YOU HAVE ANY QUESTIONS, ASK YOUR DOCTOR OR YOUR PHARMACIST.

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

BARBARA B. BLUM
Commissioner

3.0 BILLING SECTION

This section contains the information needed by the provider to properly complete the claim form.

3.1 COMMON BENEFIT IDENTIFICATION CARD

Samples of the four types of Common Benefit Identification Cards and detailed descriptions are provided in the EMEVS Provider Manual section entitled, Common Benefit Identification Cards.

NOTE: The sample cards shown in the EMEVS Provider Manual are issued to residents of New York State whose districts of fiscal responsibility are within the Medicaid Management Information System. Claims for patients with these cards should be sent to:

COMPUTER SCIENCES CORPORATION
P.O. BOX 4444
ALBANY, N.Y. 12204-0444

Claims for patients with non-MMIS Common Benefit Identification Cards should be sent to:

Local District of Fiscal Responsibility
(see Inquiry Section)

COUNTY/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	OMH Administered
98	OMR/DD Administered
99	Oxford Home

COMMON BENEFIT IDENTIFICATION CARDS

There are four types of Common Benefit Identification Cards with which you will need to become familiar; a temporary Common Benefit Identification Card, a photo card, a non-photo card and a replacement card. Presentation of a Common Benefit Identification Card 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. 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.

As indicated on pg. 3-1 of this manual, a detailed description of each type of Common Benefit Identification Card can be found in the EMEVS Provider Manual.

RECIPIENT OTHER INSURANCE CODES

These codes indicate other insurance carriers under which the recipient may be covered. Pages 3-4 through 3-9 of this manual list Recipient Other Insurance Codes and Coverage Codes. Information regarding recipient other insurance coverage can be obtained via EMEVS.

EMEVS Values	Other Insurance
05	Other In-patient/Out-patient
06	Group Health Inc. (GHI)
09	Union In-patient/Out-patient
10	HIP/HMO
11	Medicare (Part A) In-patient
12	Empire Blue Cross/Blue Shield of Greater NY
13	Medicare (Part B) Out-patient
15	Private HIP Out-patient
17	Medicare Senior Care In-patient
21	Veterans (New York City Only)
23	Empire Blue Cross (Blue Cross of GNY)
24	Medicare (Part A/B) In-patient/Out-patient
26	Chautauqua Regional Medical Services, Inc.
45	Empire Blue Shield (Blue Shield of GNY)
88	S/HMO Fee-for-service (No Print Value)

-A-

A1	American Postal Workers Union
A2	American Psych Mngmt
A6	Albany Co. Physicians Case Management Plan
AA	Accident Liability Benefits
AB	Aetna Casualty & Surety Co.
AC	Aetna Life Insurance Co.
AD	Aetna Variable Annuity Life Insurance Co.
AE	Agway Life Insurance & Health Co.
AG	Allstate Insurance Co.
AH	Amalgamated Life Insurance Co.,Inc.
AI	Allstate Insurance Co.
AJ	Absent Parent Responsibility
AP	American Association of Retired Persons
AQ	American Integrity Insurance Co.
AY	American Patriot Health Insurance Co.
AZ	American Progressive Health Insurance Co. of NY

-B-

B1	Blue Cross of Western Pennsylvania
B2	Blue Shield of Florida, Inc.
B3	Blue Shield of Massachusetts, Inc.
B4	Blue Cross/Blue Shield of Tennessee
B5	Blue Cross/Blue Shield of Northeast Ohio
B6	Blue Cross/Blue Shield of New Jersey
B7	Blue Choice
B8	Blue Cross - Utica (Hospital Plan Inc.)
B9	Blue Shield - Utica (Med. & Surg. Care, Inc.)
BA	Banker's Life Company
BB	Banker's Multiple Life Insurance Co.
BC	Blue Cross of Central New York
BD	Blue Cross of Northeastern New York
BE	Blue Cross of Western New York
BF	Benefit Trust Life Insurance Co.
BG	Blue Shield of Central New York
BH	Blue Shield of Northeastern New York
BI	Blue Shield of Western New York
BJ	Rochester Blue Cross (Roch. Hosp. Svcs.)
BK	Rochester Blue Shield (Genesee Valley Med. Care)
BL	Blue Cross of New Jersey
BM	Blue Shield of New Jersey
BN	Blue Cross/Blue Shield of Central NY
BO	Blue Cross/Blue Shield of Northeastern NY
BP	Blue Cross/Blue Shield of Western NY
BQ	Blue Cross/Blue Shield of Connecticut, Inc.
BR	Blue Cross/Blue Shield of Florida, Inc.
BT	Blue Cross/Blue Shield of Massachusetts, Inc.
BV	Blue Cross/Blue Shield of Vermont
BW	Blue Cross of Florida, Inc.
BX	Blue Cross/Blue Shield of Delaware
BY	Blue Cross of Massachusetts, Inc.
BZ	Blue Cross of Northeastern Pennsylvania

-C-

C1	Capital Blue Cross
C3	Capital District Physician's Hlth Plan (CDPHP)
C4	Connecticut General/INA (CIGNA)
C5	Community Blue (Buffalo area)
C6	Choicecare (Long Island)
C8	Confederation Life Insurance
CA	Champus
CB	Colonial Penn Franklin Insurance Co.
CC	Continental Assurance Co.
CD	Continental Casualty Co.
CE	Capital District PHSP
CH	CHUBB Life America
CI	Colonial Penn Insurance Co.
CJ	Columbian Mutual Life Insurance Co.
CK	Combined Life Insurance Co. of NY
CL	Service Employees of Central NY Welfare Fund
CM	Commercial Travelers Mutual Insurance Co.
CN	Catskill Area Schools Employee Benefit Plan
CO	Companion Life Insurance Co.
CP	CHP of Bassett
CR	Consolidated Mutual Insurance Co.
CS	Continental American Life Insurance Co.
CT	Continental Insurance Co.
CU	Civil Service Employees Association
CX	Capital Area Community Health Plan (HMO)
CY	Blue Cross/Blue Shield of Greater NY (HMO) Formerly Community Health Plan of GNY
CZ	Community Health Plan of Suffolk (HMO)

-D-

D1	BC/BS of the National Capital Area
D2	ERISCO
D3	Professional Insurance Agents Group
D4	Oxford Insurance Co.

-E-

EA	Empire State Mutual Life Insurance Co.
EB	Equitable Life Assurance Co.

EMEVS Values	Other Insurance
EC	Employer's Mutual Liability Insurance Co. of Wisconsin
ED	Equitable Life Insurance Co. of Iowa
EE	Equitable Variable Life Insurance Co.
EF	Executive Life Insurance Co. of NY
EG	Elder Plan (Brooklyn)
EH	Empire Plan/Metropolitan
EJ	Employer (No Print Value)
EZ	Empire Plan/Empire Blue Cross

-F-

FB	Farmers & Traders Life Insurance Co.
FD	Federal Life & Casualty Co.
FE	Fidelity and Casualty Co. of NY
FF	Fidelity Mutual Life Insurance Co.
FH	Fireman's Insurance Co. of Newark, NJ
FI	Fireman's Fund American Life Insurance
FR	Foundation Health Plan

-G-

GA	Guardian Insurance & Annuity Co., Inc.
GC	Gerber Life Insurance Co.
GG	Government Employee's Life Insurance Co.
GJ	Guardian Life Insurance Co. of America
GK	Genesee Valley Group Health Plan (HMO)

-H-

HA	Health Insurance Plan of Greater NY
HB	BCS Insurance Co. (Formerly Health Service Inc.)
HC	Health & Welfare Life Insurance Assoc.
HD	Hospital Service Corp. (BC of Jefferson Co.)
HE	Hartford Accident & Indemnity Co.
HF	Hartford Life Insurance Co.
HG	Health Source
HI	Home Life Insurance Co.
HL	Health Care Plan (HMO)
HM	HIP of Greater NJ, Inc. (HMO)
HN	Hlth Services Medical Corp. of Central NY (HMO) (Same as Prepaid Health Plan of Central NY)
HO	Hospital Plan Inc./Medical & Surgical Care Inc. (BC/BS Utica)
HP	Hospital Service Plan of the Lehigh Valley
HQ	Health Economics Group
HR	Health Shield Community Health Plan
HS	Healthways, Inc. (NJ)
HU	Healthnet
HV	Health Claim Services

-I-

IF	Independent Health Assoc. (HMO)
IH	Income Protection Policy
IJ	Independent Prepaid Health Plan
IK	Independence Blue Cross
IT	ITT Life Insurance Corp.

-J-

JA	J.C. Penney Insurance Co.
JB	John Deere Insurance Co.
JC	John Hancock Mutual Life Insurance Co.

-K-

KB	Kaiser Health Plan of the Northeast
KD	Key Food Stores Corp. Inc.
KN	ASO Health Plans

-L-

L2	Local 259 UAW
LA	Liberty Mutual Life Insurance Co.
LB	Liberty Life Assurance Co.
LC	Lincoln National Life Insurance Co. of NY
LD	Lawrence Health Care Admin. Svs.
LG	Lumberman's Mutual Insurance Co.
LH	Teamster's Local #182

-M-

MA	Metropolitan Life
MB	Mutual of Omaha Insurance Co.
MC	Massachusetts Mutual Life Insurance Co.
MD	Medi-Plan
ME	Mail Handlers Benefit Plan
MF	Medical Administrators
MG	Metropolitan Insurance & Annuity Co.
MH	Upstate Administration Service
MI	United Food Workers Local #1
MJ	Monarch Life Insurance Co.
ML	Montgomery Ward
MM	Mutual Benefit Life Insurance Co.
MN	Mutual Life Insurance Co. of NY
MP	Manhattan Health Plan (HMO)
MQ	Mohawk Valley Physician's Health Plan (HMO)
MS	Milk Plant Employee's Welfare Trust Fund
MT	Mid-Hudson Health Plan (Kingston Area)

-N-

N1	NPA (Natl Presc Admin)
NA	New York Dental Service Corp.
NB	NY School Athletic Protection Plan
NC	National Casualty Co.
ND	New York Life Insurance Co.
NE	Nationwide General Insurance Co.
NF	National Home & Health Assurance Co.
NG	Northcare
NI	National Insurance Services, Inc.
NK	Nationwide Life Insurance Co.

EMEVS Values	Other Insurance
NL	New England Mutual Life Insurance Co.
NM	North American Administrators
NO	Nova Healthcare
NR	Northwestern National Insurance Co.
NS	New Hampshire-Vermont Health Service
	-O-
OJ	Orange County MCP
	-P-
PA	Prudential
PB	Paul Revere Life Insurance Co.
PC	Phoenix Mutual Life Insurance Co.
PD	Peerless Insurance Co.
PE	Patient's Choice
PF	PCS
PM	Provident Life & Casualty Insurance Co.
PO	Provident Mutual Life Insurance Co. of Phila.
PP	Paid Prescriptions
PR	Preferred Care (HMO)
PS	Prepaid Health Plan of Central NY (HMO)
PT	Pennsylvania Blue Shield
PU	POMCO Insurance
PX	Prucare/Putnam
PY	Prudential Dental
	-Q-
QM	Qualified Medicare Beneficiary
	-R-
RE	Rochester Health Network (HMO)
RF	Rochester Hospital Service Corp./Genesee Valley Med. Care, Inc. (Rochester BC/Rochester BS)
RG	Rutgers Community Health Center (New Jersey)
	-S-
SB	SIEBA, Ltd.
SE	Sears, Roebuck & Co.
SG	Security Mutual Life Insurance Co. of NY
SH	Sentry Life Insurance Co. of NY
SQ	State Farm Life & Accident Assurance Co.
SS	State Mutual Life Assurance Co. of America
SU	Southern Conn. Community Health Plan (HMO)
SV	Security 65 Plan
SW	Suffolk Co. Physicians Case Management Plan
SX	Sanus Health Plan
SZ	Suffolk County Employee Med. Hlth. PLN/Choicecare

EMEVS Values	Other Insurance
	-T-
TA	Teacher's Insurance & Annuity Assoc. of America
TB	Travelers
TC	Transamerica Insurance Co.
TD	Transworld Life Insurance Co. of NY
TU	Traveler Health Network
	-U-
U1	Barkery & Conf Union Health Ben
UA	Union Labor Life Insurance Co.
UB	Union Mutual Life Insurance Co.
UH	United Mutual Life Insurance Co.
UL	United States Life Insurance Co.
UO	Utica Mutual Insurance Co.
UP	Union Fidelity Life of Pa.
UQ	U.S. Health Care
UR	Union Security Trust
	-V-
VA	Veterans Aid & Attendant
	-W-
WA	Washington National Life Insurance Co. of NY
WB	Workers Compensation
WE	Westchester Community Health Plan
WF	Employers of Wausau
WI	Whole Health Insurance Network
WT	Wellcare of NY
	-Z-
Z9	Pregnancy Indicator
ZB	Zurich Insurance Co.
ZZ	Composite Coverage

Recipient Insurance Codes	PCP Providers
02, 98, 99	Health Insurance Plan of NY 7 West 34th Street New York, NY 10001 (212) 630-5008
77	Lutheran Prepaid Capitation 5800 Third Avenue Brooklyn, NY 11220 (718) 630-0135
82	The Bronx Health Plan 1 Fordham Plaza (Suite 1000) Bronx, NY 10458 (718) 733-4747 Ext. 624
85	Elderplan SHMO, Inc. 6323 7th Avenue Brooklyn, NY 11220 (718) 921-7991
91	Manhattan PHSP 475 Riverside Drive (Room 1220) New York, NY 10115 (212) 870-2069
92	Metropolitan Health Plan 500 5th Avenue (27th Floor) New York, NY 10110 (212) 626-8300
A7	AETNA Health Plans of NY, Inc. 20 Waterview Boulevard Parsippany, NJ 07054 (201) 299-2381
BU	Bluecare Plus Utica Business Park 12 Rhoads Drive Utica, NY 13502-6398 (315) 798-4336
C2	Community Blue HMO 1901 Main Street PO Box 159 Buffalo, NY 14240-0159 (716) 887-8720
C7	Comprehensive Care Mgmt Corp. 2401 White Plains Road Bronx, NY 10467 (718) 920-5910
CF	Compre Care PHSP P.O. Box 222/2 Broad St. Plaza Glens Falls, NY 12801 (518) 798-3555
CG, CV	Capital District Physicians Hlth Plan 1 Columbia Circle Albany, NY 12203 (518) 452-1941
CQ	Choice Care of Long Island Corporate Center 395 North Service Road Melville, NY 11747-3127 (516) 694-4000
CW	Catholic Health Services Plan 26 Court Street Suite 1701 Brooklyn, NY 11242 (718) 935-1164
DC	Broome Managed Care Plan-SMA Mgmt Broome County DSS 36 - 38 Main Street Binghamton, NY 13905 (607) 778-2737
DD	(See DC)-Daniel J Driscoll
DE	(See DC)-Chenango Bridge
EI	Erie PCMP 1-Daigler, Gerald University Pediatrics Assoc. 219 Bryant Avenue Buffalo, NY 14222 (716) 878-7355
EK	Erie PCMP 2-Holden, David Family Medicaid Program 462 Grider Street Buffalo, NY 14215 (716) 898-5225
EL	Erie PCMP 3-Medical Group WNY 941 Washington Street Buffalo, NY 14203 (716) 882-1212
EN	Erie PCMP 3-University Med Svs David K. Miller Building 462 Grider Street Buffalo, NY 14215 (716) 898-5400
EO	Erie PCMP 3-Lancaster-Depew Peds 27 Central Avenue Lancaster, NY 14086 (716) 684-6140
EP	Erie PCMP 3-Service Medical PC P.O. Box 447 Springville, NY 14141 (716) 592-7400
EQ	Erie PCMP 3-Concord Medical Grp 210 East Main Street Springville, NY 14141 (716) 592-3616
ES	Erie PCMP 3-CPCP Group Inc. 14 Northland Avenue Buffalo, NY 14209 (716) 882-8989
FA	Family Health Services 99 South Erie Street Mayville, NY 14757 (716) 753-7397
HH	Health Source 303 Broadway Suite 321 Tarrytown, NY 10591 (914) 631-1611
HK	Health Care Plan Inc. PCP 900 Guaranty Bldg. Buffalo, NY 14202 (716) 847-1480
HT	Health Insurance Plan of NY 7 West 34th Street New York, NY 10001 (212) 630-5008

Recipient Insurance Codes	PCP Providers
HW	Same as HT HIP/Westchester
HX	HMO-CNY 307 East Fayette Street Syracuse, NY 13202 (315) 448-6871
HY	Same as HT HIP/Nassau County
HZ	Empire BC/BS Healthnet 3 Park Avenue 17th Floor New York, NY 10016 (212) 251-4649
IE, IN	Independent Health Assoc. 511 Farber Lakes Drive Williamsville, NY 14221 (716) 631-3086
IL	Independent Living for Seniors 355 North Park Drive Rochester, NY 14609 (716) 336-2025
IO	Independent Health HMO 220 White Plains Road Tarrytown, NY 10591 (914) 631-0939
MK	Managed Healthcare Systems, Inc. 16 Court Street Suite 310 Brooklyn, NY 11241 (718) 488-8888
MR	Genesee Valley Group Health HMO Option PRO 150 East Main Street Rochester, NY 14647 (716) 238-4394
MU	Mid-Hudson Health Plan Park West/Hurley Ave. Ext. P.O. Box 3786 Kingston, NY 12401 (914) 338-0202
MV	Mohawk Valley PHP, Inc. 111 Liberty Street Schenectady, NY 12305-1892 (518) 370-4793
MW	Managed Health 410 Lakeville Road New Hyde Park, NY 11042 (516) 352-2999
OC	Orange County Managed Care Plan-VOS 372 Fullerton Avenue Newburgh, NY 12550 (914) 562-4760
OD	(Same as OC)-GRA
OX	Oxford Health Plans (NY) Inc. 521 5th Avenue, 15th Floor New York, NY 10175 (203) 656-1442 Ext.33
PH	Twin Tier Mgmt 311 East Water Street Elmira, NY 14901 (607) 732-1948
PN	Primecare New York, Inc. 770 Broadway Third Floor New York, NY 10003 (212) 677-0677
PQ	Preferred Care Rochester HMO 259 Monroe Avenue Rochester, NY 14607 (716) 325-3920 Ext. 252
PV	Health Services Medical Corp. 8278 Willett Parkway Baldwinsville, NY 13027 (315) 638-2133
PW, PX	Prudential Health Plan of NY 400 Rella Boulevard Suffern, NY 10901 (914) 368-9699
SA	Syracuse PHSP 819 South Salina Street Syracuse, NY 13202 (315) 476-7921
SN	Sanus Health Plan of GNY 75-20 Astoria Boulevard Jackson Heights, NY 11370 (718) 899-5200 Ext. 304
SY	Southern Tier Pediatric PC 302 Hoffman Street Elmira, NY 14905-2263 (607) 734-3252
TH	Total Health HMO, Inc. 1010 Northern Boulevard Suite 324 Great Neck, NY 11021 (516) 773-0248
TV	Travelers Health Network P.O. Box 4745 Syracuse, NY 13221 (315) 433-5853
US, UT	US Healthcare, Inc. Government Programs 980 Jolly Road Blue Bell, PA 19422 (215) 654-6064
WC, WD, WG, WO	Wellcare of New York, Inc. Hurley Ave. Extension Parkwest Kingston, NY 12401 (914) 338-0202 Ext.2
WH	Westchester PHSP 303 South Broadway Suite 321 Tarrytown, NY 10591 (914) 631-1611
X3, X4, X5, X6, X7	Community Health Plan HMO 1202 Troy-Schenectady Road Latham, NY 12110 (518) 783-1864 Ext. 437

Third Party Health Resources

Insurance codes are used to identify third party resources other than Medicaid and Medicare, under which a client has insurance coverage. Such coverage must be utilized for payment of medical services prior to submitting claims to Medicaid. The type of coverage codes, under EMEVS, will identify what services are covered by the TPR.

Under EMEVS, information specific to third party resources and type of coverage will be reported to you when you request an eligibility verification for a Medicaid recipient. The response via the Medicaid Eligibility Terminal (MET) or the Verifone will be INS and COV codes followed by a two-digit insurance code and up to 13 alphabetic coverage codes or the word ALL indicating what services are covered. The telephone response will be insurance and coverage codes and a two-digit insurance code, and up to 13 messages or ALL indicating what services are covered. Please refer to the EMEVS Provider Manual for more detailed information on eligibility verifications.

The EMEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid recipient is covered by more than two carriers you will receive a response of ZZ as an insurance code which indicates additional insurance. To obtain coverage information when there are more than two carriers, call 1-800-343-9000.

Insurance Coverage Codes

Codes used to designate scope of benefits provided by an insurance company.

CODES	DESCRIPTION
A	Inpatient Hospitalization
B	Physician Services
C	Emergency Room
D	Clinic
E	Psychiatric Inpatient
F	Psychiatric Outpatient
H	Drugs
J	Dental
L	Nursing Home
P	Home Health Care
S	Major Medical
U	Coverage to Complement Medicare
Y	Durable Med. Equipment/Transportation
Z	Optical (New York City Only)
ALL	All of the above

3.2 Magnetic Media Claims Submission

Claims for payment of medical care, services and supplies may be submitted on a computer tape or diskette. In addition to original claims, the following types of claims can be handled on magnetic media:

- Adjustments and voids;
- Claims over 90 days from date of service, but less than 2 years old
- Claims which require Medicare and/or other third party insurance information;
- Claims which require a service authorization exception code;
- Claims which require modifiers

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 Provider Relations Department at Computer Sciences Corporation. The telephone numbers are listed in the Inquiry Section of this manual.

3.3 BILLING INSTRUCTIONS FOR PHARMACY SERVICES

This section of the Manual covers the preparation and submission of claim forms. It is important that the provider use the procedures outlined. Claim forms which do not conform to the MMIS requirements will not be processed.

The displayed sample claim form is numbered in each field to correspond with the explanations which follow.

Claim forms should be typed or printed legibly in order to reduce delays in processing. Claim forms may be submitted in quantity and enclosed in a single envelope which has been preprinted and addressed to:

COMPUTER SCIENCES CORPORATION
P.O. BOX 4444
ALBANY, NEW YORK 12204-0444

Be sure to send the original page (top copy) of the claim form and retain the carbon copy for your files.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER	3 INVOICE NUMBER	4 DATE FILLED MO DAY YR	5 PRIOR APPROVAL / AUTHORIZATION NUMBER	LINE	6 SA EXCP CODE	7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE / ORIGINAL CLAIM REFERENCE NUMBER
01 234 567 8	53096 5268	06 13 91	612 515 312 114	3		

2
Write's Pharmacy
40 Main Street
Anytown, New York 11111

8 RECIPIENT ID NUMBER CASE / LINE	9 YR OF BIRTH	10 SEX	RECIPIENT OTHER INSURANCE 11 CODE	12 RECIPIENT NAME LAST / FIRST
AA 123 45W	42	X 2		Brandon John

13 TYPE	14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	NAME 15	19	FOR OFFICE USE ONLY 20
01	8 6 5 4 3 2	Robinson Carlton		
16 TYPE	17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	NAME 18		

LINE	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006040182		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	20539	DOSS 100 mg. CAP	100	0	0		X	3.98				
3	600601	06 05 91	22623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	20930	Compound	1	PRN	0	0	X	12.95				
5														
										$ 48.83	$	$	$	$

CASE MGR. I.D. 36 — 37 TOTALS ▶

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS		
Cream - Apply, BID	TOTAL INGREDIENT COST	9.60
	COMPOUNDING FEE	.75
	DISPENSING FEE	2.60
	AMOUNT CHARGED *	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38	COUNTY*	BILLING DATE 39 MO DAY YR
Leonard Davis		14 91

*Payee must enter [illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this fo

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3-12

1. PROVIDER I.D. NUMBER
The 8-digit Medicaid Management Information System Identification Number, which is preprinted in this field, is assigned to the provider at the time of enrollment in MMIS. Any characters outside the box are for the Fiscal Agent's internal use only and are not part of the Provider's ID Number.

2. PROVIDER NAME & ADDRESS
The Provider's Name and Correspondence Address are preprinted in this field.

NOTE: It is the responsibility of the provider to notify the New York State Department of Social Services of any change of address or other pertinent information within 15 days of the change. (See Inquiry Section Page 5-1).

3 INVOICE NUMBER
The Invoice Number is preprinted in this field and may be used to facilitate provider inquiries.

4. DATE FILLED
Enter the date on which the order is filled.

Example: June 13, 1991 = 06/13/91

NOTE: In accordance with NYS policy, an original prescription must be filled within ~~14~~ 60 calendar days of the date ordered. ★ chg. this

5. PRIOR APPROVAL/AUTHORIZATION NUMBER--LINE
If the provider is billing for a prescription/order which requires prior approval or prior authorization enter the number assigned by the appropriate State agency. Also, enter the claim line number corresponding to the prior approval/authorization item in the appropriate space.

NOTE: Prior Approval numbers are assigned by the NEW York State Department of Health and Prior Authorization numbers are assigned by the New York State Department of Social Services.

6. SA EXCP CODE
Enter one of the codes from the list below, if it was necessary to provide service and a service authorization (SA) could not be obtained. Please refer to the subsection "Utilization Threshold Program Description" in the Policy Section for more information on the Utilization Threshold Program. If not applicable, leave this field blank.

CODE

J. Urgent Medical Care
K. Service rendered in a retroactive period
L. Emergency Care
M. Client has a temporary Medicaid authorization card (DSS-2831A)
N. Request from county for 2nd opinion to determine if recipient can work
P. Request for increase in recipient service limits pending.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01234567 | 2: Write's Pharmacy, 40 Main Street, Anytown, New York 11111 | 3 INVOICE NUMBER: 5309652208 | 4 DATE FILLED: MO 06 DAY 13 YR 91 | 5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 6215513214 | INC. 3 | 6 SA EXC. CODE | 7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE | ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A 3475W LINE | 9 YR. OF BIRTH: 42 | 10 SEX: X 2 | 11 RECIPIENT OTHER INSURANCE CODE | 12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 01 | 14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 5616432 | NAME 15: Robinson Carlton | 19 | FOR OFFICE USE ONLY 20

16 TYPE | 17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER | NAME 18

NO.	21 PRESCRIPTION ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 REV. REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006040182		90	30	1	5	X	11.90				
2	600600	06 05 91	2053939	DOSS 100 mg CAP	100	100	0	0	X	3.98				
3	600601	06 05 91	2613	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 09 91	2093030	Compound	1	PRN	0	0	X	12.95				
5														
				CASE MGR. I.D. 36				37 TOTALS ▶		$ 48.83	$	$	$	$

35 FOR COMPOUND USE ONLY. CIRCLE ONE LINE NUMBER ABOVE

INGREDIENTS	QUANTITY	PRICE
Caramycin Cream (R)	15Gm	$ 9.00
HC Cream 1% Prodger	15Gm	.60

DOSAGE FORM AND DIRECTIONS: Cream Apply BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

DO NOT WRITE IN THIS SPACE

CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis | COUNTY | BILLING DATE MO 06 DAY 14 YR 91 | 39

*Payee must enter co... herein signed unless it is the same as that of the provider address entered in the upper left of this form

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3-14

7. ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM

Do not write in this field when preparing an original claim form. Adjustments or voids can only be made to paid claims.

ADJUSTMENT

An adjustment is submitted if a provider wishes to correct one or more fields of one claim line of a previously paid claim or any of the information contained within fields 1-20. (NOTE: The Provider ID, Recipient ID and Group ID Numbers may not be adjusted.) If more than one claim line from the same invoice is to be adjusted, a separate invoice must be submitted for each claim line which requires adjustment.

Directions: Submit a new claim form, completing fields 1-39 entirely. Enter on line 1 the particular claim line to be adjusted. Place an X in box A, in the adjustment/void field, and enter the original claim reference number in the appropriate box. Each claim line is assigned a unique identifying number called the claim reference number, not to be confused with the invoice number or the remittance number. This number, which can be found on the Remittance Statement, corresponds to the claim line to be adjusted.

VOID

A void is used only to negate a paid claim. The previously paid amount will automatically be deducted from the provider's account.

Directions: Submit a new claim form completing fields 1-39 entirely. Enter on line 1 the particular claim line to be voided. Place an X in box V in the adjustment/void field, and enter the original claim reference number in the appropriate box. Each claim line is assigned a unique identifying number called the claim reference number, not to be confused with the invoice number or the remittance number. This number, which can be found on the Remittance Statement, corresponds to the claim line to be voided.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2: Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 53096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 6 2 5 5 3 2 1 1 4 LINE 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — CODE: ORIGINAL CLAIM REFERENCE NUMBER:

8 RECIPIENT ID NUMBER — CASE: A A 1 2 3 4 5 W LINE:

9 YR OF BIRTH: 4 2

10 SEX: X 2

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME — LAST: Brandon FIRST: John

13 ORDERING/PRESCRIBING PROVIDER — TYPE: 0 1 | 14 ID/LICENSE NUMBER: 8 6 5 4 3 2 | NAME 15: Robinson Carlton

16 TYPE: | 17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER: | NAME 18:

19:

20 FOR OFFICE USE ONLY:

LINE	21 PRESCRIPTION/ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 04018 2		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	Z 0539	DOSS 100 mg CAP.	100	100	0	0	X	3.98				
3	600601	06 05 91	Z 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z 0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR I.D. 36

37 TOTALS ▶ $ 48.83

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY. CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

38 SIGNATURE: Leonard Davis

COUNTY*:

39 BILLING DATE MO. 06 DAY 14 YR. 91

*Payee must ente herein signed unless it is the same as that of the provider address entered in the upper left of this f

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FOR A COMPLETE AND DETAILED EXPLANATION OF THE COMMON BENEFIT IDENTIFICATION CARD REFER TO SECTION 3.1

8. RECIPIENT ID NUMBER

Enter the recipient's 8-character alpha/numeric Welfare Management System (WMS) ID number in the space entitled Case, and leave the space entitled Line blank. This number is obtained from the Common Benefit ID Card.

Example:

8 RECIPIENT ID NUMBER CASE								LINE	
A	A	1	2	3	4	5	W		

NOTE: WMS ID numbers are composed of 8 characters. The first 2 are alpha, the next 5 are numeric and the last is an alpha.

If New York City is the recipient's Social Services District of fiscal responsibility and the date of service is prior to May 1, 1990, enter the recipient's 11-digit Medicaid ID Number.

Example:

8 RECIPIENT ID NUMBER CASE								LINE		
1	2	3	4	5	6	7	8	0	1	0

9. YR OF BIRTH

Enter in this field the last 2 digits of the recipient's year of birth as it appears on the Common Benefit ID Card.

Example: John Brandon was born on 04/05/42. Enter 42 in this field.

10. SEX

Place an X on M for MALE or F for FEMALE to indicate the recipient's sex.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2 Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 53096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL / AUTHORIZATION NUMBER: 6 2 5 5 3 2 1 4 LINE: 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
CODE: 1 2
ORIGINAL CLAIM REFERENCE NUMBER:

8 RECIPIENT ID NUMBER: CASE A A 1 2 3 4 5 W LINE:

9 YR OF BIRTH: 4 2

10 SEX: X (2)

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 0 1

14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8 6 5 4 3 2

15 NAME: Robinson Carlton

16 TYPE:

17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:

18 NAME:

19

20 FOR OFFICE USE ONLY

LINE	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	0 0 0 0 6 0 4 0 1 8 2		90	30	1	5		$ 11.90	$	$	$	$
2	600600	06 05 91	Z 0 5 3 9	DOSS 100 mg CAP.	100	0	0	0	X	3.98				
3	600601	06 05 91	Z 2 6 2 3	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z 0 9 3 0	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

38 SIGNATURE: Leonard Davis

COUNTY*:

39 BILLING DATE MO 06 DAY 14 YR 91

*Payee must enter [illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this fo

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3-18

11. RECIPIENT OTHER INSURANCE CODES

This code indicates other insurance carriers under which the recipient may be covered, but which are not indicated via EMEVS. If a recipient or an Ordering Provider has indicated that such coverage exists, enter the appropriate code in this field. Pages 3-4 through 3-8 of this manual list Recipient Other Insurance Codes. If no other coverage has been specified, enter 00 in this field.

12. RECIPIENT NAME

Enter the last name followed by the first name of the recipient as it appears on the Common Benefit ID Card.

Example: Brandon, John

In the case of a newborn recipient, enter the Mother's last name. If the first name of the infant is unknown, enter the word "newborn" under the first name in this field.

13. TYPE (LICENSE-ORDERING/PRESCRIBING PROVIDER)

When a State License number is entered in Field 14, enter one of the 2-digit codes from the list below for the type of prescriber who has issued the prescription/order.

NYS Physician (MD or DO)	01
NYS Dentist	02
NYS Other Prescriber	03
NYS Podiatrist	26
NYS Certified Nurse Practitioner	29
Out-of-state Physician (MD or DO)	11
Out-of-state Dentist	12
OTHER Out-of-state Prescriber	13
Out-of-state Podiatrist	36

NOTE: Registered physician's assistants, interns, and residents work under the authority of a physician, and thus code 01 or 11 should be used.

When an MMIS ID Number is entered in Field 14, leave this field blank.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER	3 INVOICE NUMBER	4 DATE FILLED MO DAY YR	5 PRIOR APPROVAL / AUTHORIZATION NUMBER	LINE	6 SA EXCP CODE	7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE	ORIGINAL CLAIM REFERENCE NUMBER
01 234 567 8	53096 5268	06 13 91	6125531214	3			

2 Write's Pharmacy
40 Main Street
Anytown, New York 11111

8 RECIPIENT ID NUMBER CASE	LINE	9 YR OF BIRTH	10 SEX	11 RECIPIENT OTHER INSURANCE CODE	12 RECIPIENT NAME LAST	FIRST
AA 12 34 5W		42	X 2		Brandon	John

13 TYPE	14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	NAME 15	19	FOR OFFICE USE ONLY 20
01	8165143121	Robinson Carlton		

16 TYPE	17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	NAME 18

LINE	21 PRESCRIPTION / ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW REFILL NUMBER	28 NO OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 0401 82		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	2 0339	DOSS 100 mg CAP	100	0	0		X	3.98				
3	600601	06 05 91	2 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	2 0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83 | $ | $ | $ | $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60
		.
		.
		.

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis

COUNTY*

BILLING DATE 39: MO 06 DAY 14 YR 91

*Payee must ente herein signed unless it is the same as that of the provider address entered in the upper left of this f

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3-20

14. ID/LICENSE NUMBER (ORDERING/PRESCRIBING PROVIDER)

Prescriptions from Private Practitioners

Enter the MMIS ID Number of the prescriber. If the prescriber is not enrolled in MMIS, enter his/her State License number.

Prescriptions from Facilities

For orders originating in a hospital, clinic, or other health care facility, the facility's MMIS ID Number may be entered only when the prescriber's MMIS ID or State License number is unavailable.

When a prescription is written by an unlicensed intern or resident, the supervising physician's MMIS ID Number should be entered. If the supervising physician is not enrolled in MMIS, his/her State License number may be entered. When these numbers are unavailable, enter the facility's MMIS ID Number.

Prescriptions from Physician's Assistants

When prescriptions have been written by a physician's assistant, the supervising physician's MMIS ID Number should be entered. If the supervisor is not enrolled in MMIS, enter his/her State License number. If these numbers are unavailable and the prescription originated in a facility, enter the facility's MMIS ID Number.

Prescriptions from Nurse Practitioners

Nurse practitioners certified to write prescriptions have a seven character license number which includes the letter "F" followed by six numeric digits.

Enter the seven character license number of the nurse practitioner

Example: F000067

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2: Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 3096 5268
4 DATE FILLED: MO 06 DAY 13 YR 91
5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 6 2 5 5 3 2 1 4 3 LINE
6 SA EXCP CODE
7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE; ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A A 0 1 2 3 4 5 W LINE
9 YR OF BIRTH: 4 2
10 SEX: X 2
11 RECIPIENT OTHER INSURANCE CODE
12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 0 1
14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8 6 5 4 3 2
15 NAME: Robinson Carlton
16 TYPE
17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
18 NAME
19
20 FOR OFFICE USE ONLY

No.	21 PRESCRIPTION/ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006040182	DOSS 100 mg. CAP	90	30	1	5	X	11.90				
2	600600	06 05 91	2039	Cold Air Humidifier	1	PRN	0	0	X	3.98				
3	600601	06 05 91	21623	Compound	1	PRN	0	0	X	20.00				
4	600602	06 05 91	20930		1	PRN	0	0	X	12.95				
5														
	CASE MGR. I.D. 36						37 TOTALS ▶			$ 48.83	$	$	$	$

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER: 1 2 3 4

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15 ml.	$ 9.00
HC Cream 1% Fougera	5 Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply sparingly

TOTAL INGREDIENT COSTS	$ 9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

DO NOT WRITE IN THIS SPACE

A CERTIFICATION: I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

38 SIGNATURE: Leonard Davis
COUNTY
BILLING DATE 39: MO 06 DAY 14 YR 91

*Payee must enter co herein signed unless it is the same as that of the provider address entered in the upper left of this form

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3-22

14. ID/LICENSE NUMBER (ORDERING/PRESCRIBING PROVIDER)

Prescriptions from Nurse Practitioners (Cont'd)

Certified nurse practitioner licenses which contain six numeric digits only (not preceded by the letter F) can write for fiscal orders only. Enter the six digit numeric license number of the nurse practitioner.

NOTE: If the MMIS ID or State License number is not on the ~~prescription~~, prescription, it is the pharmacist's responsibility to obtain it.

When providing services to a recipient who is restricted to a primary provider (physician, clinic, podiatrist or dentist) who orders pharmacy services, enter the MMIS ID number of the primary provider in this field.
DO NOT ENTER THE LICENSE NUMBER OF THE PRIMARY PROVIDER.

If the restricted recipient was referred by his/her primary provider to another provider who orders/prescribes services, the pharmacy provider must enter the ordering provider MMIS ID number in this field. If the ordering provider is not an enrolled Medicaid provider, enter his/her State license number.

15. NAME (ORDERING/PRESCRIBING PROVIDER)

Enter the last name, first name of the individual whose name appears as the prescriber on the prescription/fiscal order.

16. TYPE (OTHER REFERRING/ORDERING PROVIDER)

Leave this field blank.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 2 0 1 2 3 4 5 6 7 8

2: White's Pharmacy
40 Main Street
Anytown New York 11111

3 INVOICE NUMBER: 5 3 0 2 6 5 2 6 8

4 DATE FILLED: MO. 0 6 DAY 1 3 YR. 9 1

5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 6 2 5 5 3 2 1 4 3 LINE

6 SA EXCP CODE

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE; ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A A 1 2 3 4 5 W LINE

9 YR OF BIRTH: 4 2

10 SEX: X

11 RECIPIENT OTHER INSURANCE CODE

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 0 1

14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8 6 5 4 3 2

15 NAME: Robinson Carlton

16 TYPE

17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER

18 NAME

19

20 FOR OFFICE USE ONLY

LINE	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO.	DAY	YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	0 6	0 3	9 1	0 0 0 0 6 0 4 0 1 8 2		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	0 6	0 5	9 1	7 0 3 3 9	DOSS 100 mg. CAP	100	30	0	10	X	3.98				
3	600601	0 6	0 5	9 1	3 2 9	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	0 6	0 5	9 1	0 0 9 0	Compound	1	PRN	0	0	X	12.95				
5																

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83 $ $ $ $ $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER

INGREDIENTS	QUANTITY	PRICE
Betamycin Cream (RX)	15gm	$ 9.00
HC Cream 1% Rougera	15gm	.60

DOSAGE FORM AND DIRECTIONS: Cream Apply to BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)

38 SIGNATURE: Leonard Davis

COUNTY*

39 BILLING DATE MO. 0 6 DAY 1 4 YR. 9 1

*Payee must enter cou[illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this form

11-0071 (2/91)

3-24

17. ID/LICENSE NUMBER (OTHER REFERRING/ORDERING PROVIDER)

If the restricted recipient was referred by his/her primary provider to another provider who orders/prescribes services, enter the primary provider's MMIS ID number in this field. DO NOT ENTER THE LICENSE NUMBER OF THE PRIMARY PROVIDER.

18. NAME (Other Referring/Ordering Provider)

Enter the last name, first name of the primary provider.

19. FOR OFFICE USE ONLY

Leave this field blank.

20. FOR OFFICE USE ONLY

Leave this field blank.

THE CLAIM FORM ACCOMMODATES UP TO 5 PRESCRIPTION/ORDERS WHERE FIELDS 1-20 ARE THE SAME. IF THERE IS ANY CHANGE IN FIELDS 1-20, A NEW CLAIM FORM MUST BE SUBMITTED. EACH CLAIM LINE IS PROCESSED AS A SEPARATE CLAIM, AND IS PAID INDIVIDUALLY.

21. PRESCRIPTION/ORDER NUMBER

Enter the pharmacy prescription/order number up to 6 digits in this field.

22. DATE ORDERED

Enter original date the prescription/order was prescribed as it appears on the prescription/order signed by the prescriber.

Example: A drug was originally prescribed for a patient on 06/03/91. The prescription is being refilled on 06/13/91. Enter 06/03/91 in Field 22.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 2934 567 8

2: White's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 3096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 612 5 5 3 2 1 4 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — CODE: — ORIGINAL CLAIM REFERENCE NUMBER:

8 RECIPIENT ID NUMBER: CASE A A 1 2 3 4 5 W — LINE:

9 YR OF BIRTH: 42

10 SEX: X

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER — TYPE: 01 — ID/LICENSE NUMBER: 6 5 4 3 2

14 NAME: Robinson Carlton

15

16 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER — TYPE:

17 NAME:

18

19

20 FOR OFFICE USE ONLY

N°	21 PRESCRIPTION/ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 04018 2		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	Z 0539	DOSS 100 mg. CAP.	1	100	0	0	X	3.98				
3	600601	06 05 91	Z 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z 0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83 | $ | $ | $ | $

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Caramycin Cream (R)	15 Gm.	$ 9.00
HC Cream 2% Fougera	1 Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream — Apply BID

TOTAL INGREDIENT COST	$ 9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

DO NOT WRITE IN THIS SPACE

CERTIFICATION: I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

38 SIGNATURE: Leonard Davis

COUNTY:

BILLING DATE 39: MO 06 DAY 14 YR 91

*Payee must enter cou herein signed unless it is the same as that of the provider address entered in the upper left of this form

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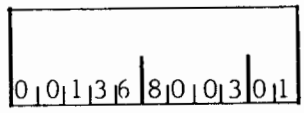
3-26

23. DRUG/SUPPLY CODE

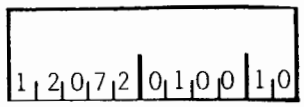
For prescription drugs, enter the National Drug Code (NDC) of the drug on the package. You will notice that the NDC is divided into 3 segments separated by hyphens. The code format on the form for the 3 segments requires 5 digits - 4 digits - 2 digits. Enter the numbers appearing in the first segment of the NDC on the package in the first 5-digit segment on the claim. If the number is not a 5-digit code, enter zeroes to the left so that all 5 spaces are filled in. In a similar fashion, fill in the remaining 2 segments of the field.

For OTC drugs, supplies and compounds, leave the first four spaces of this field blank. Enter the 5-character code from Section 4.0 of this manual in the next five spaces. Leave the next two spaces of this field blank unless a modifier is required. When a modifier is required, enter the 2-character modifier in the last two spaces of this field.

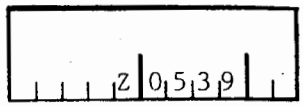
Examples: An NDC code such as 0136-8003-01 should be entered as follows:



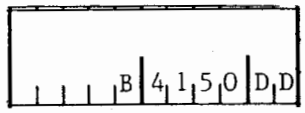
An NDC code such as 12072-100-10 should be entered as follows:



An OTC drug, Medical/Surgical supply item, such as Z0539, should be entered as follows:



A food supplement, such as B4150DD should be entered with a modifier as follows:



24. DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM

For non-prescription drugs and supplies, indicate the name of the drug or supply, the strength, and the dosage form, if applicable, as it appears on the fiscal order. For prescription drugs, this field may be left blank.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

Field	Entry
1 Provider ID Number	01234567 8
2 Provider name and address	W[illegible] Pharmacy 40 Main Street Anytown, New York 11111
3 Invoice Number	5530965268
4 Date Filled (Mo/Day/Yr)	06 13 91
5 Prior Approval/Authorization Number	62155321114
Line	3
6 SA Excp Code	
7 Only to be used to adjust or void a paid claim — Code / Original Claim Reference Number	
8 Recipient ID Number (Case / Line)	AA12345W
9 Yr of Birth	42
10 Sex	X
11 Recipient Other Insurance Code	
12 Recipient Name (Last, First)	Brandon John
13 Type	01
14 Ordering/Prescribing Provider ID/License Number	8615143 12
15 Name	Robinson Carlton
16 Type	
17 Other Referring/Ordering Provider ID/License Number	
18 Name	
19	
20 For Office Use Only	

Line No.	21 Prescription/Order Number	22 Date Ordered (Mo Day Yr)	23 Drug/Supply Code	24 Drug/Supply Name, Strength and Dosage Form	25 Quantity Dispensed	26 Days Supply	27 New/Refill Number	28 No. of Refills Authorized	29 Brand Necessary	30 Amount Charged	31 Medicare Approved	32 Medicare Paid	33 Other Insurance Paid	34 Balance Due
1	600001	06 03 91	00006040182		90	30	1	5	X	$ 11.90	$.	$.	$.	$.
2	600600	06 05 91	20539	DOSS 100 mg. CAP	1	100	0	0	X	3.98	.	.	.	.
3	600601	06 05 91	22623	Cold Air Humidifier	1	PRN	0	0	X	20.00	.	.	.	.
4	600602	06 05 91	20930	Compound	1	PRN	0	0	X	12.95	.	.	.	.
5										.	.	.	.	.

36 Case Mgr. I.D.	37 TOTALS ▶	$ 48.83	$.	$.	$.	$.

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY CIRCLE ONE LINE NUMBER 1 2 3 4 5

Ingredients	Quantity	Price
Garamycin Cream (R)	150m	9.00
HC Cream 1% Fougera	150m	.60
		.
		.
Total Ingredient Cost		9.60
Compounding Fee		.75
Dispensing Fee		2.60
Amount Charged		12.95

Dosage Form and Directions: Cream Apply BID

CERTIFICATION: I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Signature 38	County*	Billing Date 39 (Mo Day Yr)
Leonard Davis		06 14 91

Payee must enter coun wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

*-11-0071 (2/91)

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25. QUANTITY DISPENSED

When completing this field, enter only the appropriate numbers; do not enter the quantity abbreviation, e.g., "mls." Please follow the instructions for birth control pills, OTC drugs and medical/surgical supplies carefully since errors are often made when this field is completed for these items.

To determine units pricing, use the rules below in filling out claim forms.

LEGEND DRUGS:

- All units of a quantity, where applicable, must be expressed in the metric system.

  e.g.: A pint bottle of a liquid is billed as milliliters and the quantity supplied should be "473."

  e.g.: A 2 oz. bottle of a liquid is billed as milliliters and the quantity supplied should be "60."

  e.g.: A 2 oz. unit of a solid or semi-solid is billed as grams and the quantity supplied should be "60."

- All units of "Quantity Dispensed" must be rounded up to the next whole unit.

  e.g.: A 3.5 gm. tube of ophthalmic ointment is billed as a quantity of "4" (gms).

  e.g.: A 28.4 gm. tube of cream is billed as a quantity of "29" (gms).

- All liquid preparations that are dispensed in unbroken bottles must be billed for the same number of units (mls) as appears on the label. If the prepackaged quantity is not in whole units, it must be rounded up to the next whole unit.

  e.g.: Cough Preparation, 472.8 mls. bottle, is billed as a quantity of "473."

- All reconstituted medications must be expressed in terms of milliliters.

  Example: Oral penicillins and penicillin derivatives are priced by the number of mls. dispensed.

  e.g.: Ampicillin Suspension, 5 ml. - 125 mg., 100 ml, is billed as a quantity of "100."

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2: Write's Pharmacy
40 Main Street
AnyTown, New York 11111

3 INVOICE NUMBER: 53096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL / AUTHORIZATION NUMBER: 6 2 5 5 3 2 1 1 4 LINE 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE; ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A A 1 2 3 4 5 W LINE

9 YR. OF BIRTH: 42

10 SEX: X 2

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 01

14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8 6 5 4 3 2

15 NAME: Robinson Carlton

16 TYPE:

17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:

18 NAME:

19:

20 FOR OFFICE USE ONLY:

NO.	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS' SUPPLY	27 NEW/ REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 05 91	00006 04018		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	Z 0539	DOSS 100 mg CAP	100	0	0		X	3.98				
3	600601	06 05 91	Z 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z 0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83 $ $ $ $ $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY. CIRCLE ONE LINE NUMBER: 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm	$ 9.00
HC Cream 1% Fougera	15Gm	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED*	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

38 SIGNATURE: Leonard Davis

COUNTY*:

39 BILLING DATE: MO 06 DAY 14 YR 91

*Payee must enter co herein signed unless it is the same as that of the provider address entered in the upper left of this form

11-0071 (2/91)

3-30

25. QUANTITY DISPENSED (Cont'd)

Example: Powders for rectal administration are priced by the number of mls. dispensed.

e.g.: Cortenema, 100 mg/60 ml., is billed as a quantity of "60."

- All legend drugs are billed by the appropriate unit (e.g.: Caps, Tabs, Packets, Suppositories, etc.) with the following exceptions:

Example: Ampules are billed in ml. units.

e.g.: Lasix Ampules, 20 mg/cc, five 2 ml. ampules, are billed as a quantity of "10."

Vials are billed as number of ml.

e.g.: Demerol, 100 mg/ml, one 20 ml. vial, is billed as a quantity of "20."

- Birth control pills are billed as tablet units.

e.g.: Ovral-21 is billed as a quantity of "21."

- Medicated tapes are considered to be in a package and are billed as "1" unit.

e.g.: Cordran tape, 4 mcgm. per sq. cm., 3" x 24", is billed as "1" (roll).

OVER-THE-COUNTER DRUGS AND PHARMACY SUPPLIES

- Over-the-counter drugs and pharmacy supplies are dispensed as unbroken packages and are billed as "1" unit.

e.g.: Aspirin, 300 mg, 100 tabs, is billed as a quantity of "1."

e.g.: Cotton Pads, abdominal 5" x 9" 25's is billed as a quantity of "1."

- Swabs are considered to be in a package and are "1" unit.

e.g.: Alcohol swabs, 100's, are billed as a quantity of "1."

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER	3 INVOICE NUMBER	4 DATE FILLED MO DAY YR	5 PRIOR APPROVAL/ AUTHORIZATION NUMBER	LINE	6SA EXCP CODE	7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE / ORIGINAL CLAIM REFERENCE NUMBER
01 234 567 8	53096 5268	06 13 91	62 5 5 3 2 1 4	3		

2
Write's Pharmacy
40 Main Street
Anytown, New York 11111

8 RECIPIENT ID NUMBER (CASE / LINE)	9 YR OF BIRTH	10 SEX	11 RECIPIENT OTHER INSURANCE CODE	12 RECIPIENT NAME (LAST / FIRST)
AA12345W	42	X		Brandon John

13 TYPE	14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	15 NAME	19	20 FOR OFFICE USE ONLY
01	8 6 5 4 3 2	Robinson Carlton		
16 TYPE	17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	18 NAME		

No.	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 0401 82		90	30	1	5	X	$ 11.90	$.	$.	$.	$.
2	600600	06 05 91	Z0539	DOSS 100 mg. CAP	1	100	0	0	X	3.98	.	.	.	.
3	600601	06 05 91	Z2623	Cold Air Humidifier	1	PRN	0	0	X	20.00	.	.	.	.
4	600602	06 05 91	Z0930	Compound	1	PRN	0	0	X	12.95	.	.	.	.
5										.	.	.	.	.

CASE MGR. I.D.	36	37 TOTALS ▶	$ 48.83	$.	$.	$.	$.

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY. CIRCLE ONE LINE NUMBER: 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm	$ 9.00
HC Cream 1% Fougera	15Gm	.60
		.
		.

DOSAGE FORM AND DIRECTIONS		
Cream - Apply, BID	TOTAL INGREDIENT COST	9.60
	COMPOUNDING FEE	.75
	DISPENSING FEE	2.60
	AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38	COUNTY*	39 BILLING DATE MO DAY YR
Leonard Davis		06 14 91

*Payee must enter cou[...]herein signed unless it is the same as that of the provider address entered in the upper left of this form. ʼ1-0071 (2/91)

3-32

26. DAYS SUPPLY

Enter the number of days for which the prescription/order was written.

Example: Enter 30-day supply as: | 3 0 |
Be sure to right justify the numbers.

If the prescription/order directs the patient "to take when necessary," enter PRN in this field.

Example: | P R N |

27. NEW/REFILL NUMBER

Enter a 0 in this field, if an original prescription/order. If the order is a refill, indicate the number of the refill.

Example: Enter 1 for first refill. Enter 5 for fifth refill.

28. NUMBER OF REFILLS AUTHORIZED

Enter the number of refills indicated on the prescription form for the particular drug/supply ordered. This number may not exceed 5 for drugs or supplies. If no refills are indicated on the prescription, enter 0 in this field.

29. BRAND NECESSARY

If the prescription form indicates "daw" in the Dispense As Written box and prescribers write "brand necessary" or "brand medically necessary" in their own handwriting on the face of the prescriptions, pharmacists must place an X on Y for Yes in the proper field to indicate brand dispensed (when multiple source generic drugs affected by Upper Payment Limits are available) for claims to be paid at EAC prices.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER	3 INVOICE NUMBER	4 DATE FILLED MO DAY YR	5 PRIOR APPROVAL/ AUTHORIZATION NUMBER	LINE	6 SA-EXCP CODE	7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE / ORIGINAL CLAIM REFERENCE NUMBER
0 1 2 3 4 5 6 7 8	5 3 0 9 6 5 2 6 8	0 6 1 3 9 1	6 2 5 5 1 3 2 1 1 4	3		

2 White's Pharmacy
40 Main Street
Anytown, New York 1111

8 RECIPIENT ID NUMBER: CASE / LINE	9 YR OF BIRTH	10 SEX	11 RECIPIENT OTHER INSURANCE CODE	12 RECIPIENT NAME: LAST / FIRST
A A 1 3 2 3 4 5 W	4 2	X 2		Brandon / John

13 TYPE	14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER / NAME	15	19	FOR OFFICE USE ONLY 20
0 1	8 1 6 5 4 3 2	Robinson Carlton		

16 TYPE	17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER / NAME	18

LINE	21 PRESCRIPTION / ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	0 6 0 3 9 1	0 0 0 0 6 0 4 0 1 8 2		9 0	3 0	L	5	X	$ 11.90	$	$	$	$
2	600600	0 6 0 5 9 1	Z 0 1 3 9	DOSS 100 mg CAP	1 0 0	0	0		X	3.98				
3	600601	0 6 0 5 9 1	Z 2 6 2 3	Gold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	0 6 0 5 9 1	Z 0 9 3 0	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36 — 37 TOTALS ▶ $ 48.83 $ $ $ $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply - BID

TOTAL INGREDIENT COST	$ 9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis — COUNTY — BILLING DATE 39: MO 0 6 DAY 1 4 YR 9 1

*Payee must enter co[illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this form

11-0071 (2/91)

3-34

30. AMOUNT CHARGED**

Enter your usual and customary charge to the public for the quantity of the drug/supply dispensed.

NOTE: On occasion, pharmacists will be involved in rendering services which are used by the recipient to meet spend-down requirements. Spend-down is a method by which an individual establishes Medicaid eligibility by incurring a pre-determined amount of medical expenses in order to qualify him/her for participation in Medicaid. If an individual meets his/her spend-down requirement during the purchase of a drug or supply, the pharmacist should enter in Field 30, the Medicaid fee or the usual and customary charge; in Field 33, the amount paid by the individual which has fulfilled his/her spend-down requirement; and in Field 34, the amount due from Medicaid (the difference between Fields 30 and 33). Prior to billing Medicaid, the pharmacist must be certain through discussion with the local social services district that the recipient's spend-down has been met and that he/she is Medicaid eligible.

Example: The recipient's spend-down is $20.00. The Pharmacy supplies an item costing $35.00. The amount charged is $35.00, the other insurance paid is $20.00 and the balance due is $15.00.

DO NOT FILL OUT FIELDS 31 AND 32 UNLESS THE RECIPIENT IS ALSO A MEDICARE BENEFICIARY

31. MEDICARE APPROVED

It is the responsibility of the provider to determine whether the service being billed for is covered by the recipient's Medicare coverage. 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.

** The figures on the opposite page are for sample purposes only. These amounts are not to be taken as accurate figures for reimbursement. Please note that prices are subject to change periodically. Refer to Section 4.0 OTC/SUPPLY/COMPOUND Codes, of this Manual and the New York State List of Medicaid Reimbursable Drugs: Non-Prescription Drugs and Prescription Drugs.

After billing Medicare, enter the amount that Medicare has approved for payment. If Medicare denies payment, enter $0.00.

If the provider knows that the service billed would not be covered by Medicare, enter $0.00 in this field.

NOTE: Services not normally covered by Medicaid are ineligible for Medicaid reimbursement even if Medicare has approved the service.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2: Wrute's Pharmacy
405 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 530965268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL/AUTHORIZATION NUMBER: 6215312143 LINE

6 SA EXCP CODE

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM — CODE — ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE AA12345W LINE

9 YR OF BIRTH: 42

10 SEX: X

11 RECIPIENT OTHER INSURANCE CODE

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 01

14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8654321

15 NAME: Robinson Carlton

16 TYPE

17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER

18 NAME

19

20 FOR OFFICE USE ONLY

21 PRESCRIPTION/ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1 600001	06 03 91	00006040182		90	30	1	5	X	$ 11.90	$	$	$	$
2 600600	06 05 91	2 0239	BOSS 100 mg CAP	100	0	0	0	X	3.98				
3 600601	06 05 91	2 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4 600602	06 05 91	2 0930	*Compound	1	PRN	0	0	X	12.95				
5													

CASE MGR I.D. 36

37 TOTALS ▶ $ 48.83 $ $ $ $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
*Garamycin Cream (R)	15Gm.	$ 9.00
Hc Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis

COUNTY

BILLING DATE 39: MO 04 DAY 14 YR 91

*Payee must enter co[illegible]erein signed unless it is the same as that of the provider address entered in the upper left of this form

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32. MEDICARE PAID

Enter the amount actually paid for this service by Medicare in this field, after the deductible and/or co-insurance amount has been subtracted from the Medicare-approved amount. If Medicare denies payment, enter $0.00. Please Note; a claim should not be submitted to Medicaid if the Medicare Paid amount is greater than or equal to the Medicaid fee.

If the provider knows that the service billed would not be covered by Medicare, enter $00.00 in this field.

33. OTHER INSURANCE PAID

This field must be filled in if the recipient is covered by insurance other than Medicare. It is the responsibility of the provider to determine whether the service being billed for is covered by the recipient's other-insurance carrier. 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 the other-insurance carrier, as Medicaid is always the payer of last resort. Enter the amount actually paid by the other-insurance carrier in this field. If the provider bills and is denied payment by the other-insurance carrier for the particular service, enter $0.00 in this field.

The following is a list of situations in which a provider may validly enter $0.00 in the Insurance Paid Section of any Medicaid Claim Form:

1. 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 for whenever the insurance policy changes. Proof of denials must be maintained in the client'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) advised you to zero-fill. This communication should be documented in the client's billing record.

2. The provider bills the insurance company and receives a rejection because:

   - The service is not covered; or

   - The deductible has not been met.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01234567 8

2: Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 53096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL / AUTHORIZATION NUMBER: 6 2 5 5 1 3 2 1 1 4 LINE 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE; ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A A 1 2 3 4 5 W LINE

9 YR OF BIRTH: 42

10 SEX: X 2

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 01 14 ID/LICENSE NUMBER: 8 6 5 4 3 2 1 NAME 15: Robinson Carlton

16 TYPE: 17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER: NAME 18:

19:

FOR OFFICE USE ONLY 20:

NO.	21 PRESCRIPTION / ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 04018 2		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	2 05399	DOSS 100 mg CAP	100	0	0	0	X	3.98				
3	600601	06 05 91	2 26231	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	2 09300	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis

COUNTY*:

BILLING DATE 39: MO 06 DAY 14 YR 91

*Payee must enter ... herein signed unless it is the same as that of the provider address entered in the upper left of this f...

...-11-0071 (2/91)

3-38

33. OTHER INSURANCE PAID (Con't)

3. 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. Since June 1, 1992 LDSS have new subrogation rights enabling them to complete claim forms on behalf of uncooperative policy holders who do not pay the provider for the services. The local social services 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 policy holders who are uncooperative in paying for covered services received by their dependents who are on Medicaid. In other cases you'll be instructed to zero-fill your Medicaid claim and the LDSS will retroactively pursue the third party resource.

4. 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.

5. The provider is instructed to zero-fill by the LDSS for circumstances not listed above.

Leave this field blank if the recipient has no health insurance other than Medicare.

34. BALANCE DUE

Enter the net amount due after deduction of Medicare and/or other insurance payments. When Fields 32 and 33 are left blank, this field may be left blank.

DO NOT WRITE IN FIELD 35 UNLESS YOU ARE SUBMITTING A CLAIM FORM WHICH CONTAINS ONE COMPOUNDED PRESCRIPTION. PROVIDERS MAY ONLY SUBMIT ONE COMPOUNDED PRESCRIPTION PER CLAIM FORM.

35. FOR COMPOUND USE ONLY: (Please print clearly)

Ingredients: Indicate each ingredient (as specified on the prescription) on a separate line in this area. Indicate the manufacturer's name.
Quantity: Enter the metric quantity of each ingredient.
Price: Enter the cost of the ingredients.
Dosage Form and Directions: Indicate the form of the final preparation, i.e., cream, capsules, ointment, etc. Also state the physician's directions in this box.
Total Ingredient Cost: Enter the total cost of the compounded prescription.
Compounding Fee: Enter the fee for compounding a prescription.
Dispensing Fee: Enter the fee for dispensing a prescription.
Amount Charged: Enter the total amount charged. Also, be sure to enter this total amount in Field 30 on the appropriate claim line.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER	3 INVOICE NUMBER	4 DATE FILLED MO DAY YR	5 PRIOR APPROVAL / AUTHORIZATION NUMBER	LINE	6 SA EXCP CODE	7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE / ORIGINAL CLAIM REFERENCE NUMBER
01 234 567 8	53096 5268	06 13 91	612151513121 14	3		

2 Write's Pharmacy
40 Main Street
Anytown, New York 11111

8 RECIPIENT ID NUMBER CASE / LINE	9 YR OF BIRTH	10 SEX	RECIPIENT OTHER INSURANCE 11 CODE	12 RECIPIENT NAME LAST / FIRST
AA12345W	42	X 2		Brandon John

13 TYPE	14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER	15 NAME	19	FOR OFFICE USE ONLY 20
01	8654321	Robinson Carlton		
16 TYPE	17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER	18 NAME		

LINE	21 PRESCRIPTION / ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006 04018 2		90	30	1	5	X	$ 11.90	$	$	$	$
2	600600	06 05 91	Z 0539	DOSS 100 mg CAP	100	0	0		X	3.98				
3	600601	06 05 91	Z 2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z 0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36 — 37 TOTALS ▶ $ 48.83

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

38 SIGNATURE: Leonard Davis — COUNTY* — BILLING DATE 39: MO. 06 DAY 14 YR. 91

*Payee must enter [illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this f[illegible]

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36. CASE MANAGER ID

Leave this field blank.

37. TOTALS

This field may be left blank.

38. SIGNATURE

The individual who has the legal responsibility for the operation of the pharmacy must sign each claim form. Rubber stamp signatures are not acceptable.

NOTE: Do not write in the blank space above SIGNATURE. This space is for the Fiscal Agent's office use.

COUNTY OF SUBMITTAL

NOTE: Enter the name of the county wherein the claim form is signed.

The County of Submittal field may be left blank only when the provider's address, as printed on the bottom right corner of the claim form, is within the county wherein the claim form is signed.

39. BILLING DATE

Indicate in 2-digit numbers the month, day and year on which the claim form is submitted.

Example: June 14, 1991 = 06/14/91

SPECIAL NOTE: In accordance with the following regulation, claims must be submitted within 90 days of the Date the prescription was filled unless the cited circumstances can be documented.

540.6 Billing for medical assistance (Additional statutory authority, Social Services Law § 363a, 367b, 368a, 368b.) (a) Claims for payment by any provider of medical assistance must be submitted within 90 days of the date of service to be valid and enforceable, unless the submission which is made more than 90 days after the date of service, is due to circumstances outside of the control of the provider. Such circumstances include but are not limited to: involvement of third party insurer, legal proceedings or determination of client eligibility. All claims by any provider of medical assistance which are submitted after 90 days from the date of service must be accompanied by a statement of the reasons for such delay and must be submitted within 30 days from the time submission came within the control of the provider. (b) Any claim returned to any provider for reasons of data insufficiency or invalidity may be resubmitted within 60 days of the date of notification advising him of such insufficiency or invalidity.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2 Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 53096.5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL / AUTHORIZATION NUMBER: 6125513211 LINE 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE; ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE AA12345W LINE

9 YR OF BIRTH: 42

10 SEX: X 2

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 ORDERING/PRESCRIBING PROVIDER TYPE: 01

14 ID/LICENSE NUMBER: 8654321

15 NAME: Robinson Carlton

16 OTHER REFERRING/ORDERING PROVIDER TYPE:

17 ID/LICENSE NUMBER:

18 NAME:

19

20 FOR OFFICE USE ONLY

LINE	21 PRESCRIPTION/ ORDER NUMBER	22 DATE ORDERED MO DAY YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/ REFILL NUMBER	28 NO OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1	600001	06 03 91	00006040182		90	30	1	5		$ 11.90	$	$	$	$
2	600600	06 05 91	Z0539	DOSS 100 mg CAP	100	0	0		X	3.98				
3	600601	06 05 91	Z2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4	600602	06 05 91	Z0930	Compound	1	PRN	0	0	X	12.95				
5														

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Caramycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

SIGNATURE 38: Leonard Davis

COUNTY*:

BILLING DATE 39: MO 06 DAY 14 YR 91

*Payee must enter [illegible] herein signed unless it is the same as that of the provider address entered in the upper left of this fo

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39. BILLING DATE (Cont'd)

CLAIMS OVER NINETY DAYS (BUT LESS THAN TWO YEARS OLD)

In order to submit claims after 90 days, but less than 2 years from the date of service entered on the claim form, the following requirements must be met:

Valid Explanation - SIX ACCEPTABLE REASONS for late submission are:

- Litigation involving the payment of the claim (must be submitted within thirty days from the time submission came within the control of the Provider).
* - Medicare and other third party processing delays (must be submitted within thirty days from the time submission came within the control of the Provider).
- Delay in Medicaid Client Eligibility Determination, including fair hearing (must be submitted within thirty days from the time of notification).
- Original claim rejected or denied due to a reason unrelated to the 90 day regulation (must be resubmitted within sixty days of the date of notification).
** - Administrative delay (enrollment process, prior approval process, rate changes, etc.) by the department of other State agency.
- IPRO denial/reversal.

If your reason for submitting claims after 90 days does not fall within the reasons listed, you must submit an appeal in writing requesting a waiver to:

New York State Department of Social Services
Division of Health and Long Term Care
Bureau of MMIS Operations Management
Attention: Research Unit
P.O. Box 1935
Albany, New York 12201-1935

The request must give a detailed explanation for the delay including each recipient name, client identification number (CIN), date(s) of service to be submitted under the waiver. **DO NOT SEND DOCUMENTATION WITH THE REQUEST.** If your appeal is accepted, a waiver letter will be issued which is to be attached to your claims when submitting for payment.

* Explanation of Medical Benefits should not be attached to the invoice. However, the EOMB should be kept on file for audit purposes.

* Claims submitted after 90 days, but less than 2 years from the date of service, involving Medicare and/or Other Insurance, do not require a letter of explanation as an attachment.

** Claim delayed because of the prior approval process do not require any explanation/attachment, if submitted within 90 days of the date of the prior approval notification.

NOTE: The 30 day, 60 day and 90 day submission periods referred to are calendar days.

Single Submission - Attach a cover letter of one or more pages to the invoice, state the invoice number and indicate one of the acceptable reasons for late submission as shown above. This cover letter should be exactly the same size and paper quality as that of the actual invoice.

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

1 PROVIDER ID NUMBER: 01 234 567 8

2: Write's Pharmacy
40 Main Street
Anytown, New York 11111

3 INVOICE NUMBER: 53096 5268

4 DATE FILLED: MO 06 DAY 13 YR 91

5 PRIOR APPROVAL / AUTHORIZATION NUMBER: 612 515 312 1 14 LINE 3

6 SA EXCP CODE:

7 ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE 2 ORIGINAL CLAIM REFERENCE NUMBER

8 RECIPIENT ID NUMBER: CASE A A 12345 LINE W

9 YR OF BIRTH: 42

10 SEX: X

11 RECIPIENT OTHER INSURANCE CODE:

12 RECIPIENT NAME: LAST Brandon FIRST John

13 TYPE: 01

14 ORDERING/PRESCRIBING PROVIDER ID/LICENSE NUMBER: 8165 1432

15 NAME: Robinson Carlton

16 TYPE:

17 OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER:

18 NAME:

19:

20 FOR OFFICE USE

21 PRESCRIPTION / ORDER NUMBER	22 DATE ORDERED MO	DAY	YR	23 DRUG/SUPPLY CODE	24 DRUG/SUPPLY NAME, STRENGTH AND DOSAGE FORM	25 QUANTITY DISPENSED	26 DAYS SUPPLY	27 NEW/REFILL NUMBER	28 NO. OF REFILLS AUTHORIZED	29 BRAND NECESSARY	30 AMOUNT CHARGED	31 MEDICARE APPROVED	32 MEDICARE PAID	33 OTHER INSURANCE PAID	34 BALANCE DUE
1 600001	06	03	91	00006040182		90	30	1	5	X	$ 11.90	$	$	$	$
2 600600	06	05	91	Z0539	DOSS 100 mg CAP	100	0	0	0	X	3.98				
3 600601	06	05	91	Z2623	Cold Air Humidifier	1	PRN	0	0	X	20.00				
4 600602	06	05	91	Z0930	Compound	1	PRN	0	0	X	12.95				
5															

CASE MGR. I.D. 36

37 TOTALS ▶ $ 48.83 $ $ $ $ $

DO NOT WRITE IN THIS SPACE

35 FOR COMPOUND USE ONLY: CIRCLE ONE LINE NUMBER 1 2 3 4 5

INGREDIENTS	QUANTITY	PRICE
Garamycin Cream (R)	15Gm.	$ 9.00
HC Cream 1% Fougera	15Gm.	.60
		.
		.

DOSAGE FORM AND DIRECTIONS: Cream - Apply, BID

TOTAL INGREDIENT COST	9.60
COMPOUNDING FEE	.75
DISPENSING FEE	2.60
AMOUNT CHARGED	$ 12.95

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

38 SIGNATURE: Leonard Davis

COUNTY*:

39 BILLING DATE MO 06 DAY 14 YR 91

*Payee must enter erein signed unless it is the same as that of the provider address entered in the upper left of this fo

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39. BILLING DATE (cont'd)

Batch Submission - Submit the claims with a cover letter of one or more pages detailing one of the acceptable reasons for late submission shown above. The preprinted number of each invoice in the batch must appear only on the front side of the cover letter. If there are more invoice numbers to be listed, please use an additional page or pages.

CLAIMS OVER TWO YEARS OLD

Claims submitted more than two years from the date of service will be considered for payment **ONLY** if the following conditions are met:

1. The provider was not able to submit the claim within two years from the date of service for reasons beyond his/her control (i.e. because of eligibility or litigation). These claims, however, must still be submitted within 30 days of the time they came within the control of the provider. These claims must be submitted on paper along with the appropriate documentation (i.e. copy of document from the local district or court which indicates the date of decision) to the Fiscal Agent.

2. The claim was initially received by MMIS within two years from the date of service and the provider has kept the claim in an active status in conformance with the 60 day resubmission requirements (i.e. a claim that has been denied must be resubmitted within 60 days from the date of notification of denial).

   These claims along with the appropriate documentation to demonstrate that the provider is in conformance with timely submission requirements should be sent to:

   New York State Department of Social Services
   Division of Health and Long Term Care
   Bureau of MMIS Operations Management
   P.O. Box 1935
   Albany, New York 12201-1935
   Attention: Research Unit

   Acceptable documentation should include the following:

   - Copy of remittance which proves that the claim was initially submitted within two years of the date of service.

   - Copies of subsequent remittances which indicate that the claim has remained active.

3.4 REMITTANCE STATEMENT

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Statement, a sample of which appears on page 3-48. Refer to Section 3.4.3 for a column-by-column explanation of the Remittance Statement. This document plays an important role in the communication between the provider and the Fiscal Agent. Aside from showing a record of transactions, the Remittance Statement will assist providers in resolving and correcting possible errors on denied claims.

NOTE: Before any claim is entered into the computer system, it will be screened for obvious missing or erroneous data. The claim will be rejected if required data is missing or invalid. REJECTED CLAIMS ARE RETURNED TO THE PROVIDER IMMEDIATELY AS THEY WERE SUBMITTED. SINCE THEY ARE NOT ENTERED INTO THE COMPUTER SYSTEM, THEY ARE NOT SHOWN ON THE REMITTANCE STATEMENT.

MMIS produces a Remittance Statement for each payment cycle which contains all claims that have entered the computerized processing system. The Remittance Statement indicates the status of the claims (paid/pend/deny) by category within which invoices are listed in numerical order.

3.4.1 Pended Claims

A claim may be pended if it contains erroneous information, does not match the State master files, or requires manual review in order to be resolved. The pended claim will be reviewed by the Fiscal Agent, the New York State Department of Social Services or the Office of Health Systems Management.

When a payment cycle is executed, any claim which has been pended during the current cycle will appear on the Remittance Statement with an appropriate message. Messages, as shown on the illustrated sample on page 3-48, indicate the basis for the claim pending as well as the status of the claim.

Pended claims may be approved for payment, reduced or denied. The following are examples of circumstances which commonly cause claims to be pended:

- Recipient number invalid;
- New York State Medical Review required;
- Procedure requires manual pricing.

3.4.2 Denied Claims

A claim will be denied if service rendered is not covered by the New York State Medicaid Program, if it is a duplicate of a prior claim, if the required Prior Approval is not obtained or if data is invalid or logically inconsistent.

The provider should review his/her copy of the denied claim, which is indicated on the Remittance Statement and, where appropriate, completely resubmit the claim utilizing a new invoice. (Providers should not resubmit claims which have been denied due to practices which contradict either good medical practice or program policy.) The Fiscal Agent will not accept an annotated photocopy or duplicate copy of an original invoice for purposes of resubmission. Any resubmission of this sort will be classified as a REJECT and returned intact to the provider.

It is incumbent upon you to take all steps necessary to ensure that your claims are submitted as soon as possible to avoid having them denied because of age. The regulation requiring submission of claims within 90 days still applies, as do the permissible exceptions.

3-48 (Rev. 2/95)

MEDICAID MANAGEMENT INFORMATION SYSTEM

MEDICAL ASSISTANCE (TITLE XIX) PROGRAM REMITTANCE STATEMENT

PAGE 01
DATE 10/18/91
CYCLE 739

TO: WHITE'S PHARMACY
40 MAIN STREET
ANYTOWN, NEW YORK 11111

PHARMACY
PROVIDER ID 00153301
REMITTANCE NO 91102187321

(1) PROVIDER INVOICE #	(2) LINE #	(3) PRESC #	(4) ITEM CODE	(5) RNT	(6) QUANTITY	(7) DOSAGE UNT	(8) RECIP. ID #	(9) RECIP. NAME	(10) OFF. ACCT #	(11) SERVICE DATE	(12) CLAIM REFERENCE NUMBER	(13) CHRGD	(14) PAID	(15) REMARKS	
90404 9985	01	600900	00004100728		100	LIQ	AA25318X	GOURDINE		09/04/91	912693011041013	4.70	4.70	ADJ.	ADJ TO PAID CLAIM
90404 9963	01	600900	00004100728		100	LIQ	AA25318X	GOURDINE		09/04/91	912323001036052	3.80	3.80-	ADJ.	ORIGINAL AS PAID 09/25/91
90404 9972	01	600819	00000474402		1	PKG	BB33213W	SMITH		08/19/91	912693011051013	1.59	0.00	VOID	VOID TO PAID CLAIM
90404 9951	03	600819	00000474402		1	PKG	BB33213W	SMITH		08/19/91	913232001039031	1.59	1.59-	VOID	ORIGINAL AS PAID 09/25/91
90404 9908	01	600500	00004100728		100	LIQ	CC24571T	WILLIAMS		09/04/91	912693011047017	4.70	4.70	PAID	
90404 9912	02	600600	00000677302		1	CAP	AA12345W	BRANDON		09/10/91	912693011051037	3.87	3.87	PAID	
90404 9912	04	600602	00000200930		1	CPD	AA12345W	BRANDON		09/10/91	912693011053052	12.08	12.08	PAID	
90404 9984	01	600912	00000474402		1	PKG	GG44332S	PARSON		09/10/91	902693311055013	1.59	**	PEND 00162	MANUAL REVIEW
90405 1102	01	600909	10910000201		30	CRM	EF77334Y	FIELDS		09/10/91	912603311059021	2.83	*	DENY 00551	ITEM NOT ELIGIBLE FOR PYMT
90405 1231	01	600900	00004100728		100	LIQ	AA25318X	GOURDINE		09/19/91	912693311061013	4.70		PAID	

* = PREVIOUSLY-PENDED-CLAIM
** = NEW PEND

3.4.3 EXPLANATION OF COLUMNS ON REMITTANCE STATEMENT

(1) PROVIDER INVOICE NUMBER

This column indicates the Invoice Number which was preprinted on the claim form.

(2) LINE NO.

This column refers to the line number of each claim as it appears on the claim form.

(3) PRESCRIPTION NO.

The Pharmacy Prescription/Order Number, which may be no more than 6 digits, is entered in this column.

(4) ITEM CODE

The DRUG/SUPPLY CODE of each item furnished by the recipient, is listed in this column.

(5) RNT (RENTAL)

This column is left blank.

(6) QUANTITY

The quantity of the drug or supply dispensed is indicated in this column. (See field 25 of the claim form explanation.)

(7) DOSAGE UNIT

The dosage form of the drug or supply dispensed appears in this column.

(8) RECIPIENT ID NUMBER

This column lists the recipient Medicaid ID Number.

(9) RECIPIENT NAME

This column indicates the name of the recipient. If an invalid recipient Medicaid I.D. Number has been entered on the claim form, no name will appear in this column.

(10) OFFICE ACCOUNT NUMBER

The Office Account Number is optional for the provider and will only appear if it has been indicated on the claim form.

(11) SERVICE DATE

The service date entered in this column is the date the prescription or order was filled.

(12) CLAIM REFERENCE NUMBER

The Claim Reference Number, which appears in this column, is a unique identifier assigned to each claim line submitted.

(13) CHARGED

This column indicates the amount charged to Medicaid.

(14) PAID

The amount of the Medicaid payment is listed in this column.

(15) REMARKS

The status of each claim line, along with any appropriate message, appears in this column.

~~3.4.4 INFORMATION SERVICES~~

The Remittance Statement, as described above, is the key control document which informs the provider of the current status of submitted claims. Should further information be required on any detail on the Remittance Statement, the Inquiry Section provides the telephone number and address for contacting the Fiscal Agent for clarification.

3.5 REJECTED CLAIM FORMS

The purpose of this section is to explain procedures for the provider to follow when a claim has been rejected.

A claim will be rejected when information is either obviously incorrect or omitted from the claim form. If the Fiscal Agent's manual prescreening detects such an error, the original claim form will be returned to the provider with a letter (see sample on the following page) that depicts the claim form and identifies where the error was made.

Instructions for Examining Rejected Claim Form

Refer to the rejection form letter in order to see what information was omitted or was incorrect. Please enter or correct the information on the original invoice and resubmit the claim form. Be sure to attach the rejection form letter to the claim form.

3.6 TAPE SUBMISSION

Refer to Inquiry Section, page 5-2, for address or telephone number to request tape submission information.

COMPUTER SCIENCES CORPORATION

P.O. BOX 4444

ALBANY, NEW YORK 12204-0444

SUBJECT: PHARMACY CLAIM FORM **DATE:**

DEAR PROVIDER:

The enclosed invoice(s) are being returned for correction of the item(s) coded and/or circled on the claim form shown below. Please make the necessary revisions and return the original forms for processing. Please remember that your manual is an important source of relevent MMIS information and that an effective utilization of this information will expedite the processing of your claims.

The corrected claim form(s) should be enclosed in the pre-printed envelope with the next group you submit. Please attach this form with your corrected claim form(s).

- [1] MISSING INFORMATION
- [2] INCOMPLETE INFORMATION
- [3] ILLEGIBLE INFORMATION
- [4] INVALID INFORMATION
- [5] INVALID ATTACHMENTS
- [6] OTHER _____

IF YOU HAVE ANY QUESTIONS REGARDING THE COMPLETION OF THIS FORM
PLEASE CALL PROVIDER RELATIONS PROFESSIONAL SERVICES UNIT (800) 522-5535

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM
PHARMACY CLAIM FORM

PROVIDER ID NUMBER	INVOICE NUMBER	DATE FILLED MO DAY YR	PRIOR APPROVAL/ AUTHORIZATION NUMBER	LINE	SA EXCP CODE	ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM: CODE (A V)	ORIGINAL CLAIM REFERENCE NUMBER

RECIPIENT ID NUMBER: CASE	LINE	YR OF BIRTH	SEX (M F)	RECIPIENT OTHER INSURANCE CODE	RECIPIENT NAME: LAST	FIRST

ORDERING/PRESCRIBING PROVIDER: TYPE	ID/LICENSE NUMBER	NAME	FOR OFFICE USE ONLY

LN	PRESCRIPTION/ ORDER NUMBER	DATE ORDERED MO DAY YR	DRUG/SUPPLY CODE	DRUG/SUPPLY NAME STRENGTH AND DOSAGE FORM	QUANTITY DISPENSED	DAYS SUPPLY	NEW/ REFILL NUMBER	NO. OF REFILLS AUTHORIZED	BRAND NECESSARY (Y N)	AMOUNT CHARGED	MEDICARE APPROVED	MEDICARE PAID	OTHER INSURANCE PAID	BALANCE DUE
1									Y N	$	$	$	$	$
2									Y N					
3									Y N					
4									Y N					
5									Y N					
					CASE MGR ID		TOTALS			$	$	$	$	$

FOR COMPOUND USE ONLY CIRCLE ONE LINE NUMBER 1 2 3 4 5		
INGREDIENTS	QUANTITY	PRICE
		$

DOSAGE FORM AND DIRECTIONS	TOTAL INGREDIENT COST
	COMPOUNDING FEE
	DISPENSING FEE
	AMOUNT CHARGED $

SIGNATURE	COUNTY	BILLING DATE MO DAY YR

PHMREJ FRM 05/01/86

3-52 (Rev. 2/95)

3.7 HOW TO OBTAIN PRIOR APPROVAL

A prior approval number which has been obtained by a prescriber and which appears on the prescription constitutes authorization for the pharmacist to fill that prescription for an eligible recipient. The pharmacist should transcribe the prior approval number from the prescription to the pharmacy claim form.

For items for which the pharmacist must obtain prior approval, the pharmacist must call the Local Professional Director of the recipient's social services district (see Inquiry Section for the appropriate telephone number).

Prior to telephoning, the pharmacist should verify the recipient's eligibility via the Electronic Medicaid Eligibility Verification System (EMEVS).

The pharmacist should be prepared to give the following information over the telephone to the Local Professional Director.

1. Pharmacy Provider Information (This information can be found on the New York State Certificate of Participation in the Medicaid Program obtained through the enrollment process.):

    a. Identification number;

    b. Name;

    c. Telephone number;

    d. Address;

    e. Borough or county in which provider is located.

2. Prescriber Information (This information should appear on the prescription or fiscal order.):

   a. Type of prescriber (Physician, Osteopathic Physician, Dentist, Podiatrist, Nurse Practitioner);

   b. License number;

   c. Name;

   d. Telephone number (if available).

3. Recipient Information (This information can be found on the recipient's Benefit Card. See Section 3.1 for a description and explanation of the Benefit Card.):

   a. Identification number;

   b. Recipient's (Patient) name;

   c. Month and year of birth;

   d. Sex;

   e. Other insurance (code and acronym) - See pages 3-4 through 3-8 of this Manual.

4. Prescription Source (if available on the prescription)
   The pharmacist should indicate where the prescription or fiscal order originated for a recipient.

   a. At the prescriber's private office;

   b. At an out-of-state skilled nursing facility or health related facility;

   c. At a shared health facility;

   d. At a hospital outpatient department;

   e. At a free standing clinic (diagnostic and treatment center).

5. Drug/Supply Code

The pharmacist must indicate the appropriate NDC or New York State code number assigned to the prescription of over-the-counter drug or supply item for which prior approval is being requested. (Pharmacies that maintain a profile should indicate any previous date on which prior approval for the drug or supply was obtained.)

6. Medication and Supply Information

The following information must be obtained from the prescription or fiscal order to be filled.

a. Name or description of the item;

b. Date ordered by the prescriber;

c. Quantity ordered;

d. Number of refills (if appropriate);

e. Strength of medication and direction for its use.

If a prior approval request is accepted by the Local Professional Director, the pharmacist will be assigned a prior approval number for the medication or supply over the phone. This prior approval number must appear in the Prior Approval/Authorization box on the Pharmacy Claim Form which is submitted for reimbursement of the prior approved item. Failure to use the assigned prior approval number will result in denial of reimbursement for the prior approved item.

THIS PAGE LEFT BLANK FOR FUTURE USE

3.8 INSTRUCTIONS FOR OBTAINING PRIOR AUTHORIZATION

These instructions describe the preparation and submission of the Prior Authorization Request Form (DSS-3706) for the Medicaid Program (Title XIX). It is imperative that these procedures are used when completing the forms. Request forms which do not conform to systems requirements will not be processed by MMIS and will be returned to the vendor for correction.

Where to Obtain Prior Authorization Forms

Podiatrists, physicians or clinics who write fiscal orders for supplies may obtain a 3-months' supply of Prior Authorization Forms.

Where to Send Inquiries Regarding Prior Authorization Procedures or Policy

Inquiries are to be made in writing and mailed to:

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
MMIS Operations - Attention: Prior Authorization Unit
P.O. Box 1935
Albany, New York 12201

Completion of Prior Authorization Form

When ordering supplies requiring prior authorization, the Ordering Provider (prescriber) completes Section 1 of the DSS-3706.

Thereupon:

- The Ordering Provider retains the last (pink) copy of the Request for his/her files.
- The Ordering Provider transmits the original and two remaining copies of the request (via the patient/recipient) to the dispenser/vendor who is to fill the order and completes Sections 2 and 3 of the DSS-3706.

* (Please Print using Black Pen)

The following definitions and instructions pertain to the completion of DSS-3706. The numbered spaces on the sample form provided correspond with these numbered explanations.

INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION REQUEST FORM (DSS-3706)

Section 1 (to be completed by Ordering Provider)

Fields 1 through 26

1. Prior Authorization Number

   Leave this field blank. This 8-digit number will be assigned by the MMIS Prior Authorization Unit upon review of the request.

DSS-3706 (Rev. 2/86)

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM — PRIOR AUTHORIZATION REQUEST

1394030

3-58 (Rev. 2/95)

1

PRIOR AUTHORIZATION NUMBER	ORDER SOURCE	ORDER DATE	RECIPIENT ID NUMBER	SEX M F	BIRTHDATE	RECIPIENT NAME

ID/LICENSE NO.	TYPE	ORDERED BY (NAME)	CODE	PRIMARY DIAGNOSIS	CODE	SECONDARY DIAGNOSIS	CODING METHOD

ORDERING PROVIDER ADDRESS	ORDERING PROVIDER PHONE NO.	PHC Y N	POSSIBLE DISABILITY Y N

RECIPIENT ADDRESS	RECIPIENT TELEPHONE NO.	RECIPIENT MEDICARE NO.	PRESCRIBER SIGNATURE

ORDER DESCRIPTION/MEDICAL JUSTIFICATION

RECIPIENT SIGNATURE (UPON RECEIPT OF EQUIPMENT) _____ DATE _____

2

ID NUMBER	CATEGORY OF SERVICE	PROVIDER NAME	ADDRESS	TELEPHONE NUMBER ( )

3

LINE	TRY EP QE	Item Code	Rental?	Reason Code	Description	Quantity Requested	Times Req.	Total Amount Requested	Action Code	Quantity Approved	Times Apprvd.	Excess Pay	Total Amount Approved
1			Y N					.					.
2			Y N					.					.
3			Y N					.					.
4			Y N					.					.

4

REVIEWERS' COMMENTS:

1 APPROVED
2 APPROVED AS SPECIFIED
3 DENIED-NON COVERED SERVICE
4 DENIED-INSUFFICIENT INFORMATION
5 DENIED-AS SPECIFIED

NOTICE: PRIOR APPROVAL DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY AND OTHER GUIDELINES SPECIFIED IN YOUR PROVIDER MANUAL. BE SURE THE RECIPIENT'S ID CARD IS CURRENT BEFORE RENDERING SERVICE.

APPROVED PERIOD OF SERVICE FROM MO DAY YR	THRU MO DAY YR	REVIEW DATE MO DAY YR	REVIEWER IDENTIFICATION NUMBER	NAME	SIGNATURE
					X

DSS-37. (Rev. 2/86)

NYS MEDICAL ASSISTANCE (TITLE XIX) PROGRAM — PRIOR AUTHORIZATION REQUEST

1394030

PRIOR AUTHORIZATION NUMBER	ORDER SOURCE	ORDER DATE	RECIPIENT ID NUMBER	SEX	BIRTHDATE	RECIPIENT NAME
	G	07 18 91	123456701 2	M X	06 14 85	Spencer, Linda

ID/LICENSE NO.	TYPE	ORDERED BY (NAME)	CODE	PRIMARY DIAGNOSIS	CODE	SECONDARY DIAGNOSIS	CODING METHOD
00123456		Brenner, John M.D.	465.9	Acute URI, NOS	.		

ORDERING PROVIDER ADDRESS	ORDERING PROVIDER PHONE NO.	PHC		POSSIBLE DISABILITY	
1 Commerce Plaza, Albany, NY 12201	(518) 555-1213	Y	X	Y	X

RECIPIENT ADDRESS	RECIPIENT TELEPHONE NO.	RECIPIENT MEDICARE NO.	PRESCRIBER SIGNATURE
40 North Pearl St., Albany, NY 12243	NONE		John Brenner, M.D.

1 ORDER DESCRIPTION/MEDICAL JUSTIFICATION

Cold Air Humidifier that will run 8-12 hours.

The patient has been diagnosed as having an acute upper respiratory infection with considerable bronchial congestion. Use of this cold air humidifier should alleviate this condition.

RECIPIENT SIGNATURE (UPON RECEIPT OF EQUIPMENT) _____ DATE _____

2

ID NUMBER	CATEGORY OF SERVICE	PROVIDER NAME	ADDRESS	TELEPHONE NUMBER
00987654	0441	R and A Pharmacy	20 North Pearl St., Albany, NY 12243	(518) 552-3456

3

LINE	TRY EP QE	Item Code	Rental	Reason Code	Description	Quantity Requested	Times Req.	Total Amount Requested	Action Code	Quantity Approved	Times Apprvd.	Excess Pay	Total Amount Approved
1		Z2623	Y X		Humidifier, Cold Air	0001		20.00					.
2			Y N					.					.
3			Y N					.					.
4			Y N					.					.

4 REVIEWERS' COMMENTS:

1 APPROVED
2 APPROVED AS SPECIFIED
3 DENIED-NON COVERED SERVICE
4 DENIED-INSUFFICIENT INFORMATION
5 DENIED-AS SPECIFIED

NOTICE: PRIOR APPROVAL DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY AND OTHER GUIDELINES SPECIFIED IN YOUR PROVIDER MANUAL. BE SURE THE RECIPIENT'S ID CARD IS CURRENT BEFORE RENDERING SERVICE.

APPROVED PERIOD OF SERVICE		REVIEW DATE	REVIEWER IDENTIFICATION		
FROM MO DAY YR	THRU MO DAY YR	MO DAY YR	NUMBER	NAME	SIGNATURE
					X

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2. Order Source
Enter the code letter which describes where the order originated.

CODE ORDER SOURCE

Hospital Outpatient Department	A
Inpatient Hospital Service	B
Treatment and Diagnostic Center	C
Residential Health Care Facility	D
Adult Home	E
Practitioner's (Prescriber's) Office	G
Patient's Home	H
P.H.C.P. Approved Speech and Hearing Center	J
P.H.C.P. Approved Amputee Center	K
ACCESS (Monroe County Long Term Care Program)	L

3. Order Date
Indicate in 2-digit numbers the month, day and year on which the order was initiated.

Example: July 18, 1991 = 07/18/91

4. Recipient ID Number
Enter the recipient's 8-character alpha-numeric Welfare Management System (WMS) ID Number in the space beginning at the left side of the field and leave the remaining 3 spaces at the right side of the field blank.

Example: Recipient ID Number (4)
A A 1 2 3 4 5 W

If New York City is the district of fiscal responsibility, and the date of service is prior to May 1, 1990, enter the recipient's 11-digit Medicaid ID Number.

Example: Recipient ID Number (4)
1 2 3 4 5 6 7 8 0 1 2

5. Recipient Sex
Verify that recipient's sex is the same as that indicated on the Common Benefit ID Card. Place an X on M for Male or F for Female.

6. Recipient Date of Birth
Indicate in 2-digit numbers the month, day and year of the recipient's birth, as listed on the Common Benefit ID Card.

Example: June 14, 1985 = 06/14/85

7. Recipient Name
Enter the last name followed by the first name of the recipient as it appears on the Common Benefit ID Card.

8. ID/License Number
Enter the Ordering Provider's 8-digit MMIS Provider ID Number. If the order originates in an Article 28 Facility, the Facility's MMIS Provider ID Number may be entered in this field only when the Ordering Provider's MMIS ID Number or State license number is unavailable. If the Ordering Provider is not enrolled with MMIS, enter his/her license number. Leave the first two spaces to the left blank, then enter the license number up to 6-digits.

Example: | ID/LICENSE NO. | 0 | 0 | 0 | 1 | 2 | 3 | 4 | 5 | or | ID/LICENSE NO. | | | 1 | 2 | 3 | 4 | 5 | 6 |

9. License Type
(Complete only if Ordering Provider does not have an MMIS Provider ID Number).

If the Ordering Provider is not enrolled with MMIS (therefore his/her license number was used instead of an MMIS ID Number), a 2-digit code from the list below must be entered to indicate his/her license type:

TYPE	IN-STATE	OUT-OF-STATE
General Practice Physician	01	11
General Surgeon	04	14
Orthopedic Surgeon	05	15
Physiatrist	06	16
Otolaryngologist	07	17
Other Physician Specialist	08	18
Physician's Assistant	09	19
Podiatrist	26	36
Nurse Practitioner	29	39
Other	03	13

10. Ordering Provider Name
Print the last name followed by the first name of the Practitioner initiating the order.

11. Primary Diagnosis Code (Information regarding medical diagnosis should be supplied only by the prescriber)

Enter the appropriate code representing the primary diagnosis. The only acceptable diagnosis coding source is the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) (See number 12 below).

12. Primary Diagnosis
Enter the diagnosis which represents the condition or symptom of the recipient which establishes the need for the item.

13. Secondary Diagnosis Code
Enter the appropriate code representing the secondary diagnosis. Leave blank if there is no secondary diagnosis. (See number 14 below).

14. Secondary Diagnosis
Enter the diagnosis which represents a secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis.

15. Coding Method
Enter the 1-digit code below which represents the International Classification of Diseases - 9th Revision - Clinical Modification.

CODE	CODING SOURCE
4	ICD-9-CM

16. Ordering Provider Correspondence Address
Enter the Ordering Provider's address. If address is a facility, include facility name.

17. Ordering Provider Phone Number
Enter the Ordering Provider's business number.

18. Physically Handicapped Children's Program (PHCP)
Indicate whether the service is related to the Physically Handicapped Children's Program. Place an X on Y for Yes or N for No.

19. Possible Disability
Indicate whether the service was for treatment of a condition which appears to be of a disabling nature (the inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months). Place an X on Y for Yes or N for No.

20. Recipient Address
Enter recipient's address.

21. Recipient Telephone Number
Enter recipient's telephone number (if a telephone number is available during business hours).

22. Recipient Medicare Number
Enter the recipient's Medicare Number, if eligible.

23. Ordering Provider Signature (Prescriber)
The Ordering Provider signs here in addition to completing and submitting a fiscal order to the Dispensing Provider. The Dispensing Provider must maintain the signed order in his/her files for 6 years following the date of payment. (Signature stamps or initials of the Ordering Provider are not acceptable).

24. Order Description/Medical Justification (Information regarding medical justification should be supplied only by the prescriber).

Enter a detailed description of the item(s) ordered and indicate the medical reason these are necessary. The justification should be related to the primary and/or secondary diagnosis. (Abbreviations may be used). Also, indicate the probable length of time the recipient will require the item and if the recipient has used this item previously.

The provider must also indicate in this field whether the condition, for which the item is being ordered, is the result of an accident or crime.

25. Recipient Signature
The recipient signs here upon receipt of the item.

26. Date
The recipient enters the date he/she signed the form.

* PLEASE PRINT USING BLACK INK

Section 2 (to be completed by Dispensing Provider)

Fields 27 through 31

27. ID Number
Enter the Dispensing Provider's 8-digit MMIS Provider ID Number. (The Dispensing Provider must be actively enrolled in MMIS on the date the order is filled in order to be eligible for reimbursement).

28. Category of Service
Enter the 4-digit Category of Service code assigned to the Dispensing Provider at the time of enrollment. If issued more than one code, use the code most appropriate for the service to be rendered.

Example: 0 4 4 1

29. Provider Name
Print the name of the Dispensing Provider. This should be the same as that preprinted on the Dispenser's Medicaid Program Claim Form C or Pharmacy Claim Form.

30. Provider Address

Print the address of the Dispensing Provider. This address should be the same as that preprinted on the Dispenser's Medicaid Program Claim Form C or Pharmacy Claim Form.

31. Telephone Number

Enter the Dispenser's business telephone number.

Section 3 (to be completed by Dispensing Provider)

Field 32 through 39

32. Request Type

Leave this field blank.

33. Item Code

This field has spaces for 11-digits. Leave the first 4 spaces at the left of the field blank. In the next 5 spaces, enter the 5 character code from the supplies/equipment/appliances fee schedule of the item(s) ordered. When entering the fee schedule code, leave the last 2 spaces blank.

Example:

				Z	2	6	2	3		

34. Rental

Since items requiring prior authorization are purchased, place an X on N for No to indicate that a rental is not requested.

35. Reason Code

Leave this field blank.

36. Description

Enter a brief description of the item.

37. Quantity Requested

Enter the number of units of the specific item being ordered in the far right column(s). Fill spaces to the left with zeros that are not filled in with digits.

Example: Quantity of 1 =

0	0	0	1

38. Times Requested

Leave this field blank.

39. Total Amount Requested

Enter the total dollar amount for the item(s) requested.

Example: 20.00

Please retain the last (yellow) copy of the form for your files, and submit the original (blue) and green copy to the address listed below:

New York State Department of Social Services
MMIS Operations - Attention: Prior Authorization Unit
P.O. Box 1935
Albany, New York 12201

NOTE: The remaining fields in Section 3 and Section 4 will be completed by the NYS Department of Social Services, MMIS Operations - Prior Authorization Unit.

3.9 ProDUR Standards: General Information

PLEASE CONSULT THE EMEVS DUR USER MANUAL FOR SPECIFIC INFORMATION RELATING TO PRODUR, ELECTRONIC CLAIMS SUBMISSION, AND EMEVS ACCESS METHODS.

3.10 EXPLANATION OF THE PROVIDER CLAIM CORRECTION FORM (CCF)

The following instructions explain the provider Claim Correction Form (CCF), which allows providers to submit correction for claims identified by MMIS as containing incorrect or incomplete information.

For instructional purposes, the form has been separated into three sections with detailed explanations of each. A total understanding of the correction technique will enable the provider to effectively use the CCF. The following points are especially important to remember.

- Each CCF identifies an individual claim line being pended by MMIS for a particular pended reason(s).

- After reviewing the copy of the original claim form and finding the error, providers may correct the information on the lower half of the CCF.

- Once completed CCFs are received by the fiscal agent, the claim corrections will be entered into the MMIS computer so that the pended claim can be resolved.

- CCFs will not be issued for every pended claim: those being held for New York State Review and claims submitted on magnetic tape or diskette cannot be corrected using a CCF; therefore, no forms will be issued for those claims.

- CCFs are read electronically. Therefore, completion in black ink is essential, and clean, clear copies, free of attachments are necessary to assure accurate processing.

- Completed CCFs must be returned to the Fiscal Agent, by the "Return By" date printed on the form. Failure to return a CCF will cause your claim line to automatically deny.

The following pages describe the CCF in detail. It is important for providers to use the procedures specified when completing and submitting CCFs.

CCF-2 (Rev. 7/87)

1

WRITE YOUR NUMERALS LIKE THIS

1	2	3	4	5	6	7	8	9	0

I AGREE TO THE CONDITIONS STATED IN THE PROVIDER CERTIFICATION BELOW

James Strong M.D.
SIGNATURE

01 / 14 / 87
DATE

2

CDR078C NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES - MEDICAL ASSISTANCE PROGRAM PAGE 12347
PROVIDER CLAIMS CORRECTION FORM DATE 12/21/8

INVOICE TYPE...PHYSICIAN

PROVIDER ID 00423111 INVOICE NO 34287655 LINE NO 01

RECIP ID AA12345W NAME DOE JOHN OFFICE ACCT NO DOE

RETURN BY 01/20/87 LOCATOR CODE 03 02 CLAIM REFERENCE NO 86350-1234-123-01-

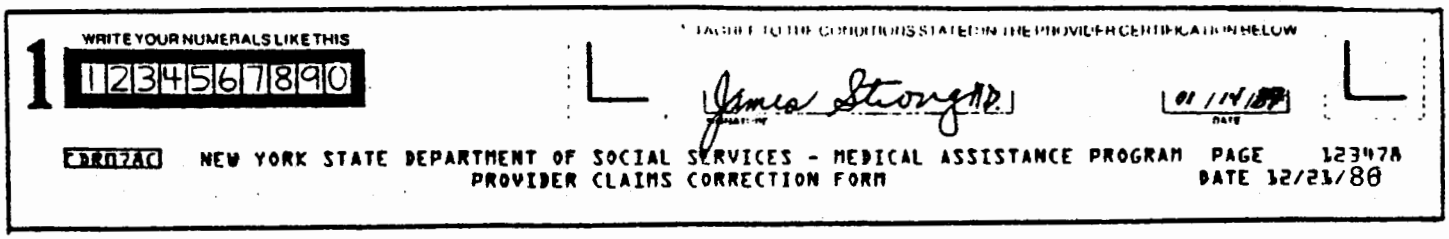
3

THIS FORM IS PROCESSED ELECTRONICALLY
DO NOT FOLD, BEND, SPINDLE, OR MUTILATE

** - PEND DESCRIPTION LINE

NAME OF FLD PENDED	CONTENTS OF FLD PENDED	PENDED FLD NO	CORR CODE	**********CORRECTION DATA********** FIELD CONTENTS	PEND REASON
** - PROCEDURE CODE NOT ON FILE OR					
** - DEACTIVATED					
1.PROC CODE	90505	0034	X	90055	00170
2.SPEC CODE		0049	C		00170
3.CATEG SVC	0460	0007	C		00170
** - MEDICARE DATA INCONSISTENT			C	==========	
** -					
1.MDCR PAID	2000	0039	C		00110
2.MDCR APP		0038	X	2500	00110
			C		

PROVIDER CERTIFICATION:I, the Provider, have reviewed this form and certify that it represents a true and accurate correction of the original claim form identified herein. I certify that the care, services and supplie itemized on this claim, as corrected by this form, have been furnished; the amounts listed are due, and except as noted, no part has been paid. I further certify that all statements made on this correction as well as o the original claim form as modified by this correction are true and complete to the best of my knowledge and that no material fact has been omitted therefrom. I understand that payment and satisfaction of this claim as corrected, will be from Federal, State and local public funds, and that the Provider and any other persons responsible may be prosecuted under applicable Federal and State laws for any false claims, statements c d or concealment of a material fact.



1. NUMBER KEY

WRITE YOUR NUMERALS LIKE THIS

1234567890

The numerals on the left indicate the manner in which numbers must be entered on this form. When using alpha characters use capital letters only. (e.g. A,B, C,....etc.) Any deviation from this format cannot be processed. Use only black ink; pencils and other color inks cannot be processed. All entries must be kept within the designated boxes; any markings outside of that area may cause a misreading.

SIGNATURE

James Strong M.D.
SIGNATURE

The provider or, where applicable, the authorized representative must sign the CCF in black ink. (Rubber stamps are not acceptable.)

DATE

01/14/87
DATE

Enter the date the provider signs the form.

PAGE

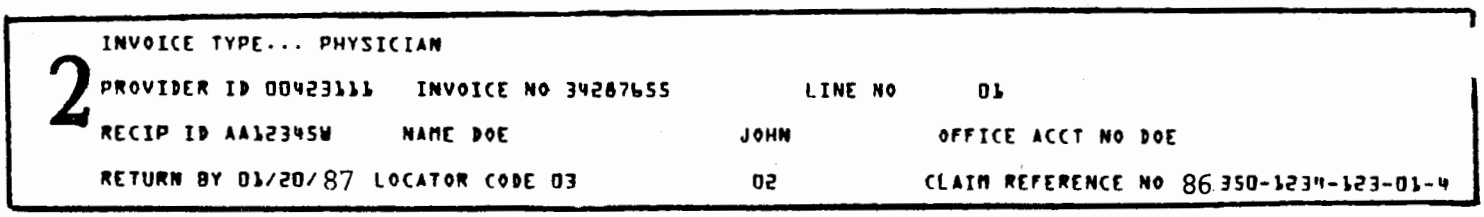
PAGE 123478

The page number relates to the location of the form as it is printed in the weekly cycle. If the provider receives more than one CCF the numbers will run consecutively. The last page of the CCF package will indicate the range of numbers which comprise the provider's package.

PRINTING DATE

DATE 12/21/86

The date the form was printed.



2. INVOICE TYPE

INVOICE TYPE... PHYSICIAN — The type of claim form submitted by the provider.

. PROVIDER ID NUMBER

PROVIDER ID 00423111 — The provider's MMIS ID number is printed here.

. INVOICE NUMBER

INVOICE NO 34287655 — The invoice number of the original claim form.

. LINE NUMBER

LINE NO 01 — The line number indicates the relationship of this claim line to others on the invoice. This would be the first claim line entered on the original claim form.

. RECIPIENT ID NUMBER

RECIP ID AA12345W — The recipient's Medicaid ID number that was entered on the original invoice is printed here.

. RECIPIENT NAME

NAME DOE JOHN

If the Recipient ID Number is incorrect or not on the New York State eligibility file, no recipient name will appear in this field.

. OFFICE ACCOUNT NUMBER

OFFICE ACCT NO DOE

If the office account number field has been completed on the original claim form, the information will appear here. For Inpatient claims, Admit/Medical Record Numbers will be indicated here. For Pharmacy claims, a Prescription/Order Number will appear.

. RETURN DATE

RETURN BY 01/20/87

This field indicates the date by which the CCF must be returned to the fiscal agent. IF the CCF is not returned by this date, the original claim will be denied.

. LOCATOR CODE

LOCATOR CODE 03

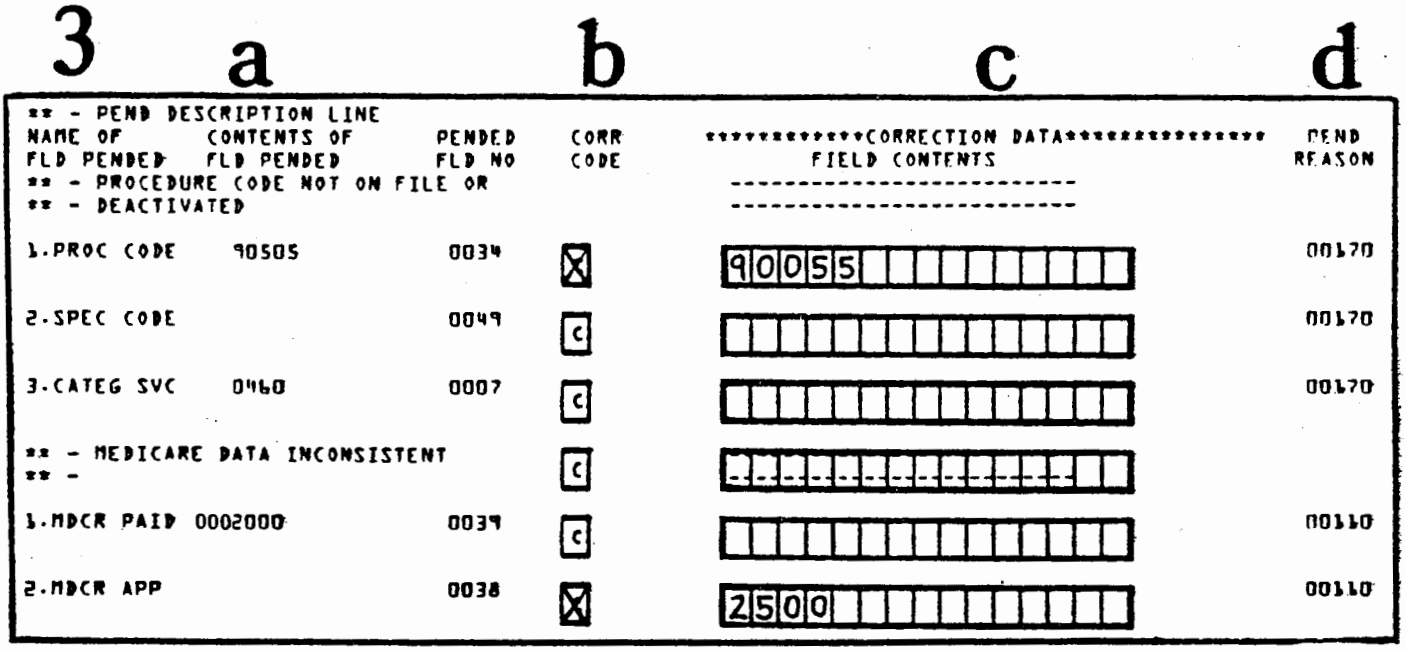
The locator code used on the original invoice will be printed here.

. CLAIM REFERENCE NUMBER

CLAIM REFERENCE NO

86 350-1234-123-01-4

This is a unique identifying number assigned by MMIS to every individual claim line and identifies the pended claim line.



3 Section 3 delineates the reason(s) the claim line was pended, indicates the field(s) on the claim form which are involved, and allows the provider to make the necessary corrections.

a . ** PEND DESCRIPTION LINE

** - PROCEDURE CODE NOT ON FILE OR
** - DEACTIVATED

This line is a message that describes the reason the claim line was pended. This claim line was pended because the procedure code was not on file (New York State Master File) or was deactivated on that file.

. NAME OF FIELD(S) PENDED

1.PROC CODE	90505
2.SPEC CODE	
3.CATEG SVC	0460

This column lists the claim form fields that could have possibly caused the claim line to pend for the reason described by the Pend Description Line. The provider should review these fields and make any appropriate corrections.

NOTE: Since all possibilities are listed, the column may show fields that are not relevant to the provider or that are correct. "Header" information (from the top portion of the original invoice) which is incorrect may cause more than one claim line to pend. For example, if more than one procedure on the invoice requires prior approval and the prior approval number is incorrect, the claim lines affected will pend.

. CONTENTS OF FIELD(S) PENDED

1.PROC CODE	90505
2.SPEC CODE	
3.CATEG SVC	0460

The information from the original claim form corresponding to the field(s) listed to the left will appear here. A blank space indicates that the field may not have been completed on the original claim form.

. PENDED FIELD NUMBER

0034

0049

0007

This number identifies the pended field name. If the abbreviation identifying the name of the field pended is not clear, please see page CCF-13 for the complete message.

b. CORRECTION CODE

[X]

[C]

[C]

If one or more of the fields listed requires a correction, place an "X" on the "C." If the information is correct, make no entry. Write only within the boundaries of the boxes

NOTE: All entries for changes and corrections are to be made on the line(s) corresponding to the field(s) listed.

C. CORRECTION DATA/FIELD CONTENTS

Enter the required correction using the appropriate alpha/numeric characters. Leave no spaces, use no hyphens, slashes, or decimal points.

X	90055	To correct required information, place an "X" on "C" in the Correction Code Column and enter the revised information in the Correction Data boxes.
X		To delete information, place an "X" on "C" in the Correction Code Column and leave the adjacent boxes blank.
C		If information for a particular field is correct and requires no change, leave these boxes blank and DO NOT place an "X" on "C."
C		If no information appears and it is not appropriate to indicate information in this field, continue to leave it blank.
X	F	To indicate sex, use M for Male and F for Female.
X	Y	When indicating YES and NO, use Y and N.
X	1450	For dollar amounts, the cents must be entered. If entering $20.00 write 2000; for $14.50, write 1450.
X	021687	Dates should be entered as month, day, and year using six digits. No slashes, spaces, or alpha characters should be used. (e.g. February 16, 1987 is entered as 021687).

d. PEND REASON (NUMBER)

00170 For internal use only.

POSSIBLE CCF CORRECTIONS

When a claim line is pended, certain fields will be listed for provider review. The examples shown have either been completed if required or left blank as appropriate.

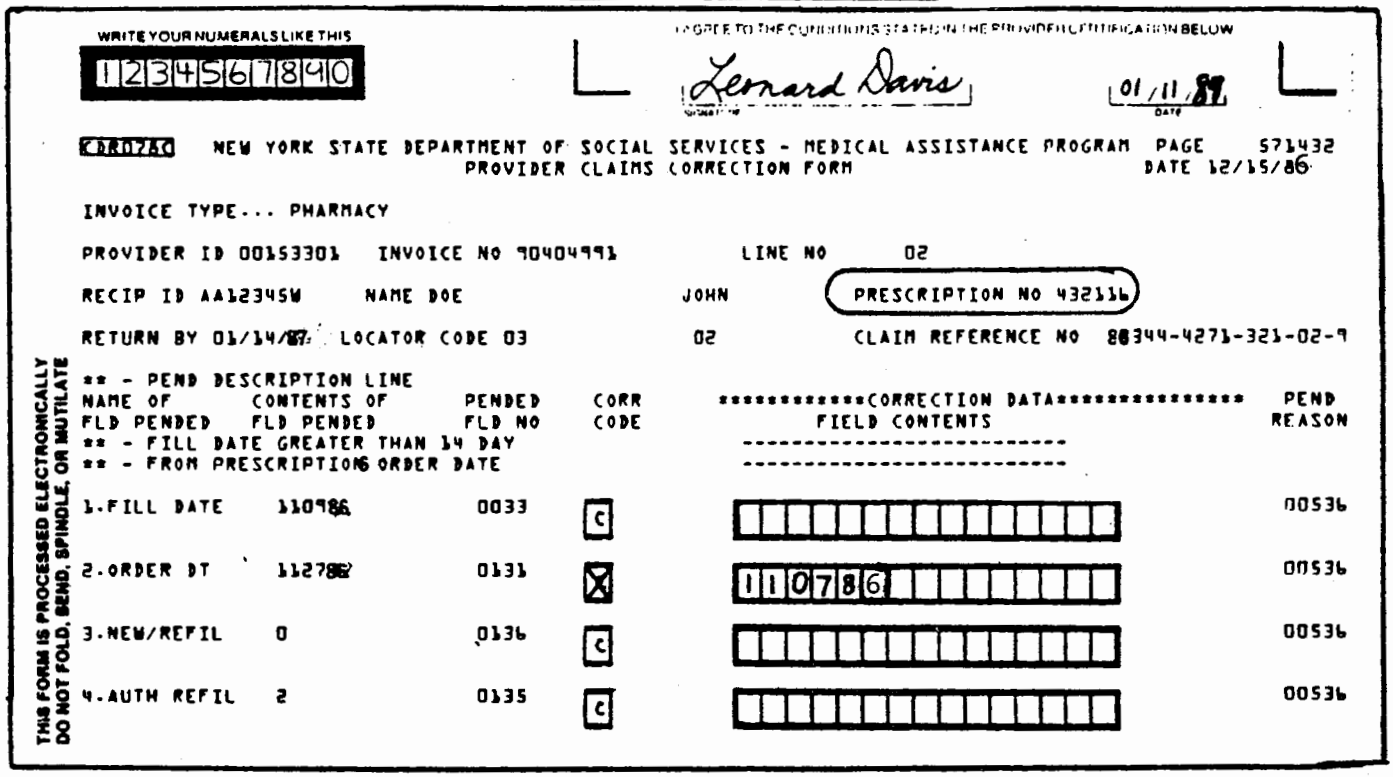
. If a change in information is necessary, place an "X" over the "C" in the Correction Code column and provide the correct information in the Field Contents boxes.

. If the listed information is correct, do not place an "X" on the "C" and continue to leave the Field Contents boxes blank.

. To delete information - place an "X" on "C" and leave the Field Contents boxes blank.
(In our example, a Medicare payment was erroneously reported. Medicare was not involved in the claim and the field should have been blank.)

. If a listed field has been left blank and it is not appropriate to indicate information in this field, do not put an "X" on the "C" and continue to leave the Field Contents boxes blank.

SAMPLE PHARMACY CCF



WRITE YOUR NUMERALS LIKE THIS
1 2 3 4 5 6 7 8 9 0

I AGREE TO THE CONDITIONS STATED IN THE PROVIDER CERTIFICATION BELOW
Leonard Davis (SIGNATURE) 01/11/87 (DATE)

CDR0240 NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES - MEDICAL ASSISTANCE PROGRAM PAGE 571432
PROVIDER CLAIMS CORRECTION FORM DATE 12/15/86

INVOICE TYPE... PHARMACY

PROVIDER ID 00153301 INVOICE NO 70404991 LINE NO 02

RECIP ID AA123456W NAME DOE JOHN PRESCRIPTION NO 432116

RETURN BY 01/14/87 LOCATOR CODE 03 02 CLAIM REFERENCE NO 88344-4271-321-02-9

THIS FORM IS PROCESSED ELECTRONICALLY DO NOT FOLD, BEND, SPINDLE, OR MUTILATE

** - PEND DESCRIPTION LINE
** - FILL DATE GREATER THAN 14 DAY
** - FROM PRESCRIPTION ORDER DATE

NAME OF FLD PENDED	CONTENTS OF FLD PENDED	PENDED FLD NO	CORR CODE	**********CORRECTION DATA********** FIELD CONTENTS	PEND REASON
1.FILL DATE	110986	0033	C		00536
2.ORDER DT	112786	0131	X	110786	00536
3.NEW/REFIL	0	0136	C		00536
4.AUTH REFIL	2	0135	C		00536

INFORMATION SPECIFIC TO PHARMACY CCFS

For informational purposes only, we have circled the field that is specific only to pharmacy and therefore has not been previously explained on the sample Physician CCF.

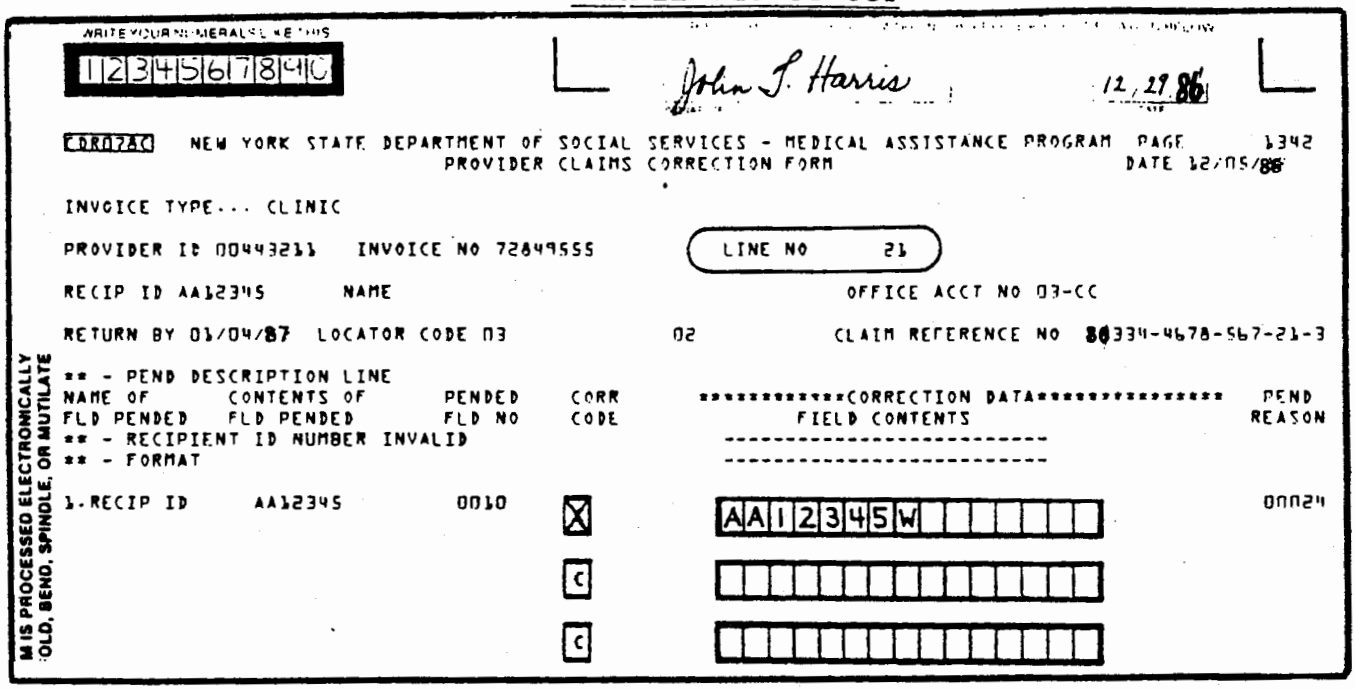
- PRESCRIPTION/ORDER NUMBER is printed only on the Pharmacy CCF.

CORRECTION PROCEDURES

This Pharmacy CCF illustrates a correction which must be completed for the claim line to process.

- As a result of the Pend Description Line, "FILL DATE GREATER THAN 14 DAYS FROM PRESCRIPTION DATE," four fields have been listed, which must be reviewed for possible error.
- The only field requiring correction was the order date. The provider marked an "X" over the "C" in the CORRECTION CODE column and placed the accurate information as shown in the FIELD CONTENTS boxes.
- The remaining fields are correct and need no further action.

SAMPLE CLINIC CCF



WRITE YOUR NUMERALS LIKE THIS
1 2 3 4 5 6 7 8 9 0

John L. Harris 12,29,86

CDR07AC NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES - MEDICAL ASSISTANCE PROGRAM PAGE 1342
PROVIDER CLAIMS CORRECTION FORM DATE 12/05/86

INVOICE TYPE... CLINIC

PROVIDER ID 00443211 INVOICE NO 72849555 LINE NO 21

RECIP ID AA12345 NAME OFFICE ACCT NO 03-CC

RETURN BY 01/04/87 LOCATOR CODE 03 02 CLAIM REFERENCE NO 80334-4678-567-21-3

M IS PROCESSED ELECTRONICALLY
FOLD, BEND, SPINDLE, OR MUTILATE

** - PEND DESCRIPTION LINE

NAME OF FLD PENDED	CONTENTS OF FLD PENDED	PENDED FLD NO	CORR CODE	**********CORRECTION DATA********** FIELD CONTENTS	PEND REASON
** - RECIPIENT ID NUMBER INVALID					
** - FORMAT					
1-RECIP ID	AA12345	0010	X	AA12345W	00024
			C		
			C		

INFORMATION SPECIFIC TO CLINIC CCFS

For informational purposes only, we have circled the Line Number field above which contains a format specific only to clinics. The line number indicates the relationship of a claim line to others on the invoice. The line numbers printed for clinics represent the following:

1st Position - Visit
2nd Position - Line corresponding to the specific visit

Example: For an invoice with two separate clinic visits during which two procedures were performed for each visit, the line numbers would be:

11 - the first visit R-Line
12 - first procedure code
13 - second procedure code

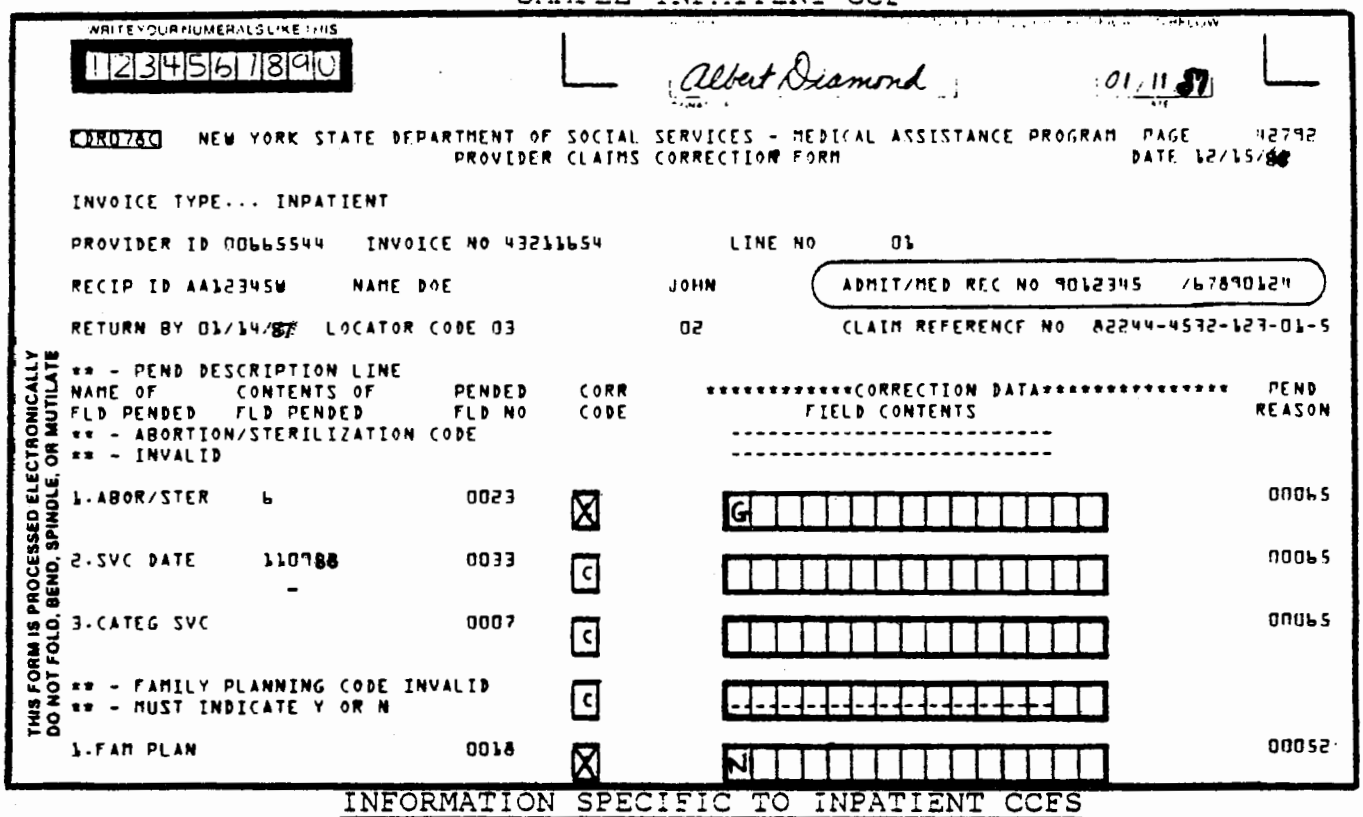
21 - the second visit R-Line
22 - first procedure code
23 - second procedure code

CORRECTIONS PROCEDURES

Each claim line which requires a correction will receive an individual CCF. In our example, LINE NUMBER 21 refers to the second R-Line. The first claim line pended would have received a separate CCF. The example used in the Pend description line indicates information in need of correction.

- For the Pend description message, "RECIPIENT ID INVALID FORMAT," one field was listed.
- Since the ID number AA12345 was incorrect, no Recipient name was printed in the RECIPIENT NAME area on the top of the CCF.
- The provider made the appropriate correction on the CCF by placing an "X" over the "C" in the CORRECTION CODE column; and writing the correct recipient ID number AA12345W in the FIELD CONTENTS boxes.

SAMPLE INPATIENT CCF



WRITE YOUR NUMERALS LIKE THIS
1 2 3 4 5 6 7 8 9 0

Albert Diamond 01/11/87

ORR076C NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES - MEDICAL ASSISTANCE PROGRAM PAGE 12792
PROVIDER CLAIMS CORRECTION FORM DATE 12/15/86

INVOICE TYPE... INPATIENT

PROVIDER ID 00665544 INVOICE NO 43211654 LINE NO 01

RECIP ID AA123456W NAME DOE JOHN ADMIT/MED REC NO 9012345 /67890124

RETURN BY 01/14/87 LOCATOR CODE 03 02 CLAIM REFERENCE NO 82244-4532-123-01-5

THIS FORM IS PROCESSED ELECTRONICALLY DO NOT FOLD, BEND, SPINDLE, OR MUTILATE

** - PEND DESCRIPTION LINE
** - ABORTION/STERILIZATION CODE
** - INVALID

NAME OF FLD PENDED	CONTENTS OF FLD PENDED	PENDED FLD NO	CORR CODE	CORRECTION DATA FIELD CONTENTS	PEND REASON
1.ABOR/STER	6	0023	X	G	00065
2.SVC DATE	110788	0033	C		00065
3.CATEG SVC		0007	C		00065
** - FAMILY PLANNING CODE INVALID ** - MUST INDICATE Y OR N			C		
1.FAM PLAN		0018	X	N	00052

INFORMATION SPECIFIC TO INPATIENT CCFS

For informational purposes only, we have circled the field that is specific to Inpatient Services and therefore has not been previously explained on the Physician CCF.

- ADMIT/MEDICAL RECORD NUMBERS are printed only on the Inpatient CCF.

CORRECTION PROCEDURES

The examples used in the pend description lines indicate information in need of correction.

- With the first pend message, "ABORTION/STERILIZATION CODE INVALID," the three fields listed must be considered for possible error.
- The abortion sterilization code entered was an error. It was corrected by marking an "X" over the "C" in the CORRECTION CODE column and placing the correct information in the FIELD CONTENTS boxes.
- For the remaining fields, where no correction was necessary the CORRECTION CODE and FIELD CONTENTS areas were left blank.
- For the second pend message, "FAMILY PLANNING CODE INVALID - MUST INDICATE Y OR N," one field was listed. The provider placed an "X" over the "C" in the CORRECTION CODE column and entered the previously omitted data in the FIELD CONTENTS boxes.

EXPLANATION OF FIELD NAMES

PENDED FIELD NO.	NAME OF FIELD PENDED	EXPLANATION
0001	PROV ID NO	Provider Identification Number
0004	BILLING DT	Billing Date, (for Inpatient Claims, Date Submitted)
0005	GROUP ID	Group ID Number
0006	LOCATOR CD	Locator Code
0007	CATEG SVC	Category of Service
0008	NO OF ATT	Number of Attachments
0009	A/V CODE	Adjustment/Void Code
0010	REC ID NO	Recipient ID Number
0012	REC YOB	Recipient Year of Birth
0013	SEX	Sex
0015	EMERGENCY	Emergency Indicator
0016	HDCP CHILD	Handicapped Children Program
0017	POSS DIS	Possible Disability
0018	FAM PLAN	Family Planning
0019	ACC CODE	Accident Code
0020	PAT STATUS	Patient Status Code
0021	CHAP REF	CHAP Referral Code
0022	RECOTH INS	Recipient Other Insurance Code
0023	ABORT/STER	Abortion/Sterilization Code
0024	PRI APP NO	Prior Approval Number
0025	PRIM DIAG	Primary/Principal Diagnosis Code
0026	PL OF SVC	Place of Service Code
0028	REFPROV ID	Ordering/Referring Provider ID/License Number
0031	DIAG TYPE	Diagnosis Code-Coding Method
0033	FILL DATE	Fill Date (For Pharmacy Service Providers Only)
0033	SVC DATE	Service Date (For Inpatient/Nursing Home-From Date)
0034	PROC CODE	Procedure Code
0036	UNITS	Units/Times Performed
0037	AMT CHGD	Amount Charged/Billed
0038	MDCR APP	Medicare Approved Amount
0039	MDCR PAID	Medicare Paid Amount
0040	OTH INS PD	Other Insurance Paid
0045	ORIG CRN	Original Claim Reference Number
0046	SEC DIAG	Secondary Diagnosis, (For Inpatient, Admit Diagnosis)
0048	SVCPROV ID	Service Provider ID/License Number
0049	SPEC CODE	Clinic Specialty Code
0051	PHYS HIST	Physical Exam-History
0052	PHYS DEVEL	Physical Exam-Growth & Development
0053	PHYS SPEAK	Physical Exam-Speech
0054	PHYS SKIN	Physical Exam-Skin
0055	PHYS HEAD	Physical Exam-Head/Neck
0056	PHYS EYE	Physical Exam-Eye
0057	PHYS EAR	Physical Exam-Ear
0058	PHYS NOSE	Physical Exam-Nose/Throat/Mouth
0059	PHYS DENT	Physical Exam-Dental
0060	DENT STAT	Physical Exam-Dental Status
0061	PHYS RESP	Physical Exam-Respiratory
0062	PHYS CARD	Physical Exam-Cardiovascular
0063	PHYS GAST	Physical Exam-Gastrointestinal
0064	PHYS UROG	Exam-Urogenital/Rectal
0065	PHYS SEX	Exam-Sexual Development
0066	PHYS MUSCL	Physical Exam-Musculo Skeletal
0067	PHYS NEURO	Physical Exam-Neurological
0068	PHYS BEHAV	Physical Exam-Behavioral
0069	PHYS VISIO	Physical Exam-Vision
0070	PHYS HEAR	Physical Exam-Hearing
0071	PHYS BP	Physical Exam-Blood Pressure
0072	LAB HEMAT	Laboratory Services-Hematocrit, HGB
0073	LAB URINAL	Laboratory Services-Urinalysis
0074	LAB UR CUL	Laboratory Services-Urine Culture
0075	LAB LEAD	Laboratory Services-Lead Screen
0076	LAB TUBER	Laboratory Services-Tuberculin
0077	LAB SICKLE	Laboratory Services-Sickle Cell
0078	LAB VDRL	Laboratory Services-VDRL
0079	LAB GC	Laboratory Services-GC
0080	LAB PAP	Laboratory Services-Pap Smear
0081	IM DPT GIV	Immunizations-DPT-Given
0082	IM DPT UTD	Immunizations-DPT-Up to Date (Incomplete/Complete)
0083	IM POL GIV	Immunizations-Polio-Given
0084	IM POL UTD	Immunizations-Polio-Up to Date (Incomplete/Complete)
0085	IM MEA GIV	Immunizations-Measles-Given
0086	IM MEA UTD	Immunizations Measles-Up to Date (Incomplete/Complete)
0087	IM MUM GIV	Immunizations-Mumps-Given
0088	IM MUM UTD	Immunizations-Mumps-Up to Date (Incomplete/Complete)
0089	IM RUB GIV	Immunizations-Rubella-Given
0090	IM RUB UTD	Immunizations-Rubella-Up to Date (Incomplete/Complete)
0091	IM DPB GIV	Immunizations-DPT-Given
0092	IM DPB UTD	Immunizations-DTP-Up to Date (Incomplete/Complete)
0093	IM POB GIV	Immunizations-Polio Booster-Given
0094	IM POB UTD	Immunizations-Polio Booster-Up to Date (Incomplete/Complete)
0095	IM TDB GIV	Immunizations-Td Booster-Given
0096	IM TDB UTD	Immunizations-Td Booster-Up to Date (Incomplete/Complete)
0097	REF(1)ITEM	Referral 1-Item Number
0098	REF(2)ITEM	Referral 2-Item Number
0099	REF(3)ITEM	Referral 3-Item Number
0100	REF(4)ITEM	Referral 4-Item Number

PENDED FIELD NO.	NAME OF FIELD PENDED	EXPLANATION
0101	1 REF PROV	Referral 1-Provider Referred To-ID Number
0102	2 REF PROV	Referral 2-Provider Referred To-ID Number
0103	3 REF PROV	Referral 3-Provider Referred To-ID Number
0104	4 REF PROV	Referral 4-Provider Referred To-ID Number
0105	1 REF SPEC	Referral 1-Clinic Specialty Code
0106	2 REF SPEC	Referral 2-Clinic Specialty Code
0107	3 REF SPEC	Referral 3-Clinic Specialty Code
0108	4 REF SPEC	Referral 4-Clinic Specialty Code
0109	1 POSS DIS	Referral 1-Possible Disability Code
0110	2 POSS DIS	Referral 2-Possible Disability Code
0111	3 POSS DIS	Referral 3-Possible Disability Code
0112	4 POSS DIS	Referral 4-Possible Disability Code
0113	1 APPT DT	Referral 1-Appointment Date
0114	2 APPT DT	Referral 2-Appointment Date
0115	3 APPT DT	Referral 3-Appointment Date
0116	4 APPT DT	Referral 4-Appointment Date
0117	MIN ADJ CD	Blue Cross Minus Adjust Code
0118	MINUS AMT	Minus Adjust
0119	SURPLUS CD	Surplus/Catastrophic/or Recurring Code
0120	SURP AMT	Surplus/Catastrophic/or Recurring Amount
0121	POST DAYS	Posted Charges Days
0122	POST CHGS	Posted Charges Amount
0123	PT-B RESP	Part-B Patient Responsibility
0124	CD METHOD	Coding Method
0128	PRESC TYPE	Type of Prescriber
0129	PRESC LIC	Prescriber License Number
0130	RX NUMBER	Prescription/Order Number
0131	ORDER DT	Date Ordered
0132	NDC/SUP CD	Drug/Supply Code
0133	QTY DISP	Quantity Dispensed
0134	DYS SUPPLY	Days Supply
0135	AUTH REFIL	Number of Refills Authorized
0136	NEW/REFILL	New/Refill Number
0137	BRAND NEC	Brand Necessary
0139	RENTAL IND	Rental
0140	REFPROV TP	Ordering/Referring Provider-Type of License (For Nursing Home-Referring/Destination/Previous Provider)
0141	COINS RATE	Coinsurance Rate
0142	LTR RATE	Life Time Reserve Rate
0143	BC RATE 1	Blue Cross Full Days Rate
0144	BC EXT AMT	Blue Cross Extension
0150	ADMIT DATE	Admit Date
0151	ADMIT HOUR	Admit Hour Code
0152	ADMIT TYPE	Admit Type
0153	ATTND PHY	Attending Physician Identification Number
0154	OPER PHY	Operating Physician Identification Number
0157	PROC DATE	Procedure Date
0158	BEN EXH DT	Medicare Benefits Exhausted Date
0159	PART-A DYS	Medicare Part-A Days
0160	COINS DAYS	Coinsurance Days
0161	LTR DAYS	Life Time Reserve Days
0162	BLOOD PTS	Blood Pints
0163	BLOOD RATE	Blood Rate
0164	PART-A DED	Part-A Deductible
0166	FULL DYS 1	Blue Cross Full Days 1st Policy
0167	FULL DYS 2	Blue Cross Full Days 2nd Policy
0168	BC EXT-1	Blue Cross Extension-1st Policy
0169	EXT 2/PLUS	Extension-2nd Policy-Plus Adjust
0170	SP PGM SFP	Special Program (Federal Funding)
0177	CHAMPUS	Champus
0180	PAT PART	Patient Participation
0181	OTHER AMT	Other Payment Amount (Including Part B Payment)
0182	NON-COVD	Non-Covered Days
0183	DISCH DATE	Discharge Date
0184	DISCH HOUR	Discharge Hour
0185	DISCH STAT	Discharge Status/Patient Status Code
0186	END DT SVC	End Date/Thru Date of Service
0190	ALT CR TP	Type of Alternate Care Required
0191	ALT CR DT	Date Alternate Care Required
0192	CRV OUT DY	Carve Out Days
0195	INPUT-IND1	Blue Cross Certificate/Group Number
0196	INPUT-IND2	Blue Cross Certificate/Group Number
0197	INPUT-IND1	Blue Cross Policy Number
0198	INPUT-IND2	Blue Cross Policy Number
0199	ADM/DEN CD	Admission/Denied Code
0205	SVCPRO TP	Service Provider-Type of License Number
0208	TOOTH QUAD	Dental-Tooth/Quadrant
0209	TOOTH SURF	Dental-Tooth Surface
0214	HIC NO	Health Insurance Claim Number
0216	MED REC NO	Medical Record Number
0217	ADMIT NO	Admit Number
0220	MDCR RATE	Medicare Coinsurance Rate
0224	TOTAL DAYS	Title XIX Days - Total
0225	HOSP LEAVE	Title XIX Days - Hospital Leave
0226	THER LEAVE	Title XIX Days - Therapeutic Leave
0235	RATE CODE	Rate Code

OTC/SUPPLY CODE

TABLE OF CONTENTS

4.0 NEW YORK STATE FEE SCHEDULE

OTC/SUPPLY CODES

GENERAL INFORMATION AND INSTRUCTIONS

1. Prior approval, dispensing validation, and prior authorization:

   a. "_____" underlined code numbers indicate that prior approval is required, utilizing form DSS3615.
   b. When the description is preceded by a "#", Electronic Medicaid Eligibility Verification System (EMEVS) dispensing validation is required.
   c. When the description is preceded by a "*", voice interactive telephone prior authorization is required. The prescriber must write the prior authorization number on the fiscal order and the dispenser completes the authorization process by calling (866) 211-1736.

2. Where the letters "PA" appear in the price column, the actual price must be determined at the time of prior approval.

3. MMIS Modifiers:

   a. The modifier 'DD' is no longer in use, effective for dates of service on and after April 1, 2002.

   b. The modifier 'BO', Orally administered enteral nutrition, must be added to the five-digit alph-numeric code as indicated, effective April 1, 2003.

4. Reimbursement for Enteral Therapy indicated By Report and unlisted Supply Items is limited to the lower of:

   -The actual acquisition cost (by invoice to the provider) plus 50%;or

   -The usual and customary charge to the general public.

5. Reimbursement for Enteral Therapy, Parenteral Therapy, listed Non-prescription Drugs and Medical/Surgical Supplies is limited to the lower of:

   -The price as indicated in the New York State Fee Schedule; or

   -The usual and customary price charged to the general public.

6. See Section 4.5 for compounded prescription billing instructions.

7. **Acquisition cost** means the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations, mailing, shipping, handling, insurance costs or any sales tax.

8. For items listed in section **4.3 Medical/Surgical Supplies, the quantity listed is the maximum allowed per month.** If the fiscal order exceeds this amount, the provider must obtain prior approval.

9. **"BY REPORT" (BR)**: When billing "By Report", appropriate documentation (e.g.: itemized invoice) indicating total cost of the item, and any other factors which may be pertinent, must be submitted with the claim.

10. **FILLING ORDERS:** An original fiscal order for Medical-Surgical Supplies may not be filled more than 60 days after it has been inititated by the ordering practitioner unless prior approval is required.

4.1 ALLOWABLE NON-PRESCRIPTION DRUGS/OTC DRUGS

Non-prescription drugs included in the therapeutic categories listed in this section may be reimbursed in the New York State Medical Assistance Program; and as a reimbursement item of medical assistance shall be the lower of:

(a) The provider's usual and customary price to the general public on the date of provision of service, but not to exceed the lower sale price, if any, in effect on that date; or

(b) The maximum reimbursable price established and maintained as listed.

For non-prescription/OTC National Drug Codes (NDC's) refer to the New York State Medicaid Reimbursable Drug List (Microfiche). All non-prescription drugs may be refilled up to five times.

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
ANALGESIC AND ANTIPYRETIC		
Acetaminophen		
Tablets		
80 mg	150	$0.0707
325 mg	500	0.0310
500 mg	500	0.0426
Liquid	600 ml	0.0234
Drops	75 ml	0.1872
Suppositories		
120-125 mg	60	0.6716
300-325 mg	60	0.7194
600-650 mg	60	0.6500
Acetylsalicylic acid		
Tablets 81 mg	180	0.0482
325 mg	500	0.0174
Tablets, enteric coated		
325 mg	500	0.0360
Suppositories 300- 325 mg	60	0.2080
650 mg	60	0.3206
Tablets, buffered	500	0.0342
Ibuprofen		
Tablets 200 mg	500	0.0647
Syrup 100 mg/5 ml	300	0.0980

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
ANTACID		
Aluminum hydroxide gel		
Suspension	2400 ml	$ 0.0145
Tablets	500	0.1065
Aluminum hydroxide, magnesium trisilicate, alginic acid and sodium bicarbonate tablets	500	0.0425
Aluminum hydroxide gel with magnesium hydroxide or trisilicate and/or simethicone and/or other antacid preparations:		
Suspension	1775 ml	0.0087
Tablets	500	0.0369
Sodium bicarbonate tablets 650 mg	500	0.0207
ANTI-DIARRHEAL		
Attapulgite Suspension	1775 ml	0.0182
Loperamide HCl Liquid 1 mg/5 ml	600	0.0664
Polycarbophil Tablets 500 mg	500 ml	0.1274
Bismuth Subsalicylate		
Tablets 262 mg	500	0.1800
Liquid 262 mg/15 ml	2400 ml	0.0215
ANTIHISTAMINE		
Brompheniramine tablets 4 mg 24's	24	0.1036
Brompheniramine tablets 4 mg	500	0.0248
Chlorpheniramine tablets 4 mg 24's	24	0.0858
Chlorpheniramine tablets 4 mg	500	0.0236
Diphenhydramine capsules 25 mg	500	0.0333
Liquid 12.5 mg/5 ml	600 ml	0.0352
ANTI-MALARIA		
Quinine sulfate 300 mg	500	0.1360
ANTI-VERTIGO		
Dimenhydrinate tablets 50 mg 12's	12	0.2254
Dimenhydrinate tablets 50 mg	500	0.0334

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
ARTIFICIAL TEARS AND OCCULAR/ORAL LUBRICANTS		
Lubricant ophthalmic ointment	18 G	$ 1.3718
Artificial tears ml/UD	75 ml	0.2793
Saliva substitute (squeeze or spray sol)	900 ml	0.0512
Sodium chloride ophthalmic		
Ointment 5%	18 G	2.5710
Solution 2%	75 ml	0.4300
5%	75 ml	0.4300
CARDIOVASCULAR		
Nicotinic acid tablets		
50 mg	500	0.0247
100 mg	500	0.0279
500 mg	500	0.0283
CHRONIC RENAL DISEASE		
Calcium tablets (500 mg elemental Ca) 1.25 G	300	0.0523
Basic aluminum carbonate gel		
Capsules 400-600 mg	500	0.1531
Tablets 300-600 mg	2500	0.1164
Suspension 400-600 mg/5 ml	1775 ml	0.0223
Calcium carbonate/simethicone 6.5 G/0.5 G (7 G) packets	150	0.3823
COUGH AND COLD		
Phenylephrine HC1 Nasal Solution 1/8%	150 ml	0.2974
Guaifenesin syrup 120 ml	120 ml	0.0190
Guaifenesin syrup	1185 ml	0.0131
Guaifenesin w/decongestant and/or antitussive drops	150 ml	0.2480
Guaifenesin capsules/tablets 200 mg	500	0.1952
Non-Narcotic antitussants and/or antihistamine and/or expectorant and/or decongestant and/or combination syrup 120 ml	120 ml	0.0268
Non-Narcotic antitussants and/or antihistamine and/or expectorant and/or decongestant and/or combination syrup	1185 ml	0.0214
Antihistamine and decongestant syrup	600 ml	0.0216
Oxymetazoline HC1 nasal solution	150 ml	0.1352
Non-Narcotic antitussants and/or upper respiratory combinations of antihistamines and decongestant tabs and caps	120	0.2076

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
COUGH AND COLD (continued)		
Decongestant syrup	600 ml	$0.0225
Decongestant tablets 30 mg	120	0.1040
Sodium chloride nasal drops/spray 0.4 - 0.9%	250 ml	0.0757
DERMATOLOGICAL		
Aluminum acetate conc. sol	2365 ml	0.0251
Bacitracin ointment	150 G	0.0829
Benzoyl peroxide		
Gel 5%	225 G	0.0803
10%	225 G	0.0854
Lotion 5%	300 ml	0.0716
10%	300 ml	0.0952
Hydrocortisone cream 1%	150 G	0.1037
Ointment 1%	150 G	0.1037
Lotion 1%	300 ml	0.0778
Iodochlorhydroxyquin (clioquinol)		
Cream 3%	150 G	0.0876
Neomycin ointment	150 G	0.0700
Tolnaftate Cream/Gel 1%	75 G	0.1493
Powder 1%	225 G	0.0735
Solution 1%	50 ml	0.2293
Antifungal vaginal cream w/applicator	45 G	0.2977
Antifungal vaginal suppositories	7	1.9285
EMETICS		
Ipecac syrup	50 ml	0.0660
FAMILY PLANNING (See Section 4.3)		
Contraceptive suppositories	60	0.6967
Contraceptive jelly kit w/applicator	114 G	0.1066
Contraceptive jelly	570 G	0.1066
Contraceptive cream	575 G	0.1090
Jelly disposable applicator	50	1.1500
Contraceptive foam kit small	200 G	0.3280
Contraceptive foam kit	450 G	0.1576

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
FECAL SOFTENER AND LAXATIVE		
Milk of Magnesia Suspension	2365 ml	$0.0083
Tablets	500	0.0457
Heavy mineral oil	2365 ml	0.0081
Docusate calcium, potassium or sodium		
Capsules 100 mg	500	0.0352
Syrup 20 mg/5 ml	2365 ml	0.0099
Solution 10 mg/ml	600 ml	0.0500
Bisacodyl suppositories 10 mg 12's	12	0.2600
Bisacodyl suppositories 10 mg	250	0.1620
Bisacodyl tablets, delayed release 5 mg	500	0.0301
Bulk laxatives, psyllium and/or methylcellulose, karaya gum, combinations, etc.	2400 G	0.0197
Barium enema prep kit	5	5.9696
Senna tablets	500	0.0415
Sugar-free psyllium powder	1500 G	0.0197
Polycarbophil Tablets 500 mg	500	0.1274
Disposable enema	6750 ml	0.0867
Disposable enema, docusate sodium	3000 ml	0.0997
Carbon dioxide releasing suppository	50	0.9830
HEMATINIC		
Ferrous Salts Tablets 300 - 325 mg	500	0.0217
Liquid	2365 ml	0.0109
Drops	250 ml	0.1008
INSULIN		

The maximum fees for insuli n are adjusted periodically by the State to reflect the current cost. Refer to the New York State Department of Health List of Medicaid Reimbursable Drugs.

INSULIN INJECTION USP	
Insulin inj. beef & pork U-100	50 ml
Insulin inj. pork ultra U-100 purified	50 ml
INSULIN SUSPENSION, ISOPHANE USP	
Isophane beef & pork U-100	50 ml
Isophane pork ultra purified U-100	50 ml
INSULIN ZINC SUSPENSION USP: ALL (PROMPT, EXTENDED, INTERMEDIATE)	
Zinc susp. beef & pork U-100	50 ml
Zinc susp. pork ultra U-100 purified	50 ml

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
INSULIN, BIOSYNTHETIC HUMAN		
Insulin injection U-100	50 ml	
Insulin suspension, isophane U-100	50 ml	
Insulin zinc suspension 70%/30%	50 ml	
Insulin isophane suspension 50% & insulin injection 50%	50 ml	
Insulin injection U-100		
3 ml Cartridge	45 ml	
1.5 ml Cartridge	45 ml	
Insulin suspension, isophane U-100		
3 ml Cartridge	45 ml	
1.5 ml Cartridge	45 ml	
Insulin suspension isophane 70% with insulin injection 30% U-100		
3 ml Cartridge	45 ml	
1.5 ml Cartridge	45 ml	
PEDICULOCIDE		
Pyrethrins (0.17 - 0.33%) w/piperonylbutoxide (2 - 4%) Liquid	600 mg	$0.0936
Permethrin creme rinse 1%	300 mg	0.1869
SMOKING CESSATION AGENTS		
Transdermal Nicotine 0-7 mg	30	3.283
8-15 mg	30	3.283
16 mg and above	30	3.203
Nicotine Gum 2 mg 108's	540	0.426
48's	48	0.556
Nicotine Gum 4 mg 108's	540	0.479
48's	48	0.625

PRODUCT/DESCRIPTION	MAXIMUM QUANTITY/MO	UNIT PRICE
VITAMIN/MINERAL		
ACD drops Solution	250 ml	$0.1350
with Iron	250 ml	0.1350
Multi-Vitamin Solution (drops)	250 ml	0.1454
with Iron	250 ml	0.1454
Capsules or Tablets	500	0.0295
with minerals	500	0.0295
Solution w/or w/o minerals 240 ml	240 ml	0.0188
Solution w/or w/o minerals	2365 ml	0.0188
Therapeutic vitamins, w/or w/o minerals		
Capsules or tablets	500	0.0504
Prenatal vitamins capsules or tablets	500	0.0604
Ascorbic Acid		
100 mg	500	0.0250
250 mg	500	0.0330
500 mg	500	0.0467
Calcium		
500 mg	500	0.0523
600 - 650 mg	500	0.0414
Pyridoxine HCl tablets (Vitamin B6)		
25 mg	500	0.0310
50 mg	500	0.0339
100 mg	500	0.0444
Thiamine HCl tablets (Vitamin B1)		
50 mg	500	0.0339
100 mg	500	0.0410
Vitamin D2 8000 IU/ml	300 ml	0.4413
Vitamin A		
10000 IU Capsules	500	0.0350
5000 IU/0.1 ml	150 ml	1.4258
Magnesium tablets	500	0.0550
UNCLASSIFIED		
Pediatric Electrolyte Sol, Oral	5000 ml	0.0077
Glucose Tablets	60	0.2674
Glucose Gel	465 gm	0.1360

4.2 ENTERAL AND PARENTERAL THERAPY

CODE	PRODUCT	QUANTITY	PRICE
	ENTERAL FORMULAE AND ENTERAL SUPPLIES		
	Enteral feeding supply kits (B4034-B4036) include whatever supplies are necessary to administer the specific type of feeding and maintain the feeding site. This includes, but is not limited to: syringes, measuring containers, tip adapters, anchoring device, gauze pads, protective-dressing wipes, tape, and tube cleaning brushes.		
B4034	**#Enteral feeding supply kit; syringe, per day**	up to 30/mo	$ 1.8772
B4035	**#Enteral feeding supply kit; pump fed, per day**	up to 30/mo	8.3203
B4036	**#Enteral feeding supply kit; gravity fed, per day**	up to 30/mo	5.1638
B4081	**#Nasogastric tubing with stylet**	up to 1/mo	16.1692
B4082	**#Nasogastric tubing without stylet**	up to 2/mo	10.0633
B4083	**#Stomach tube - Levine type**	up to 2/mo	1.0748
B4086	**#Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each** (includes replacement extension/decompression tubing for low profile tube/button/port) (see T5999, p. 4-38 for low profile kit)	up to 1/mo	22.89
B4100	**#Food thickener, administered orally, per ounce**	up to 180/mo	0.53

Enteral nutritional therapy is covered for nasogastric, jejunostomy or gastrostomy tube feeding or as a liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized (the inability to sustain oneself nutritionally by eating food) and the condition is one where enteral nutritional therapy is generally considered by the medical community as the treatment of choice to produce medical benefit. Medical necessity for enteral nutritional therapy must be substantiated by documented physical findings and/or laboratory data. The therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized prescriber. It is the responsibility of the prescriber to maintain documentation in the recipient's record regarding the medical necessity for enteral nutritional therapy. Standard milk-based infant formulas are not reimbursable by Medicaid. Non-standard infant formulas are reimbursable by Medicaid under the appropriate enteral therapy code. The calculation for pricing enteral formula is as follows: Number of calories per can divided by 100 equals the number of caloric units per can.

Effective April 1, 2003, enteral formula requires voice interactive prior authorization, as indicated by the "*" next to the code description. The prescriber must write the prior authorization number on the fiscal order and the dispenser completes the authorization process by calling (866) 211-1736. The following worksheet will assist the dispenser in completing this process.

NEW YORK STATE MEDICAID PROGRAM
ENTERAL FORMULA PRIOR AUTHORIZATION
DISPENSER WORKSHEET (Rev. 2/04)

To facilitate the process, be prepared to answer these questions when you call the voice interactive Enteral Prior Authorization Call Line at **1-866-211-1736** and choose **Option 4.**

1. Enter the 8-digit **prior authorization number** obtained by the prescriber and written on the fiscal order.	_ _ _ _ _ _ _ _
2. Enter the **recipient CIN** (Client Identification Number) of the patient for which the enteral formula is ordered. The automated system will then confirm that a valid, unused prior authorization number exists for this patient. (Client ID number is 2 alpha/5 numeric/1 alpha.)	_ _ _ _ _ _ _ _
3. Enter your MMIS **Provider ID Number.**	_ _ _ _ _ _ _ _
4. Enter your Pharmacy (0161, 0288 or 0441) or DME (0160, 0287, 0321, 0323 or 0442) **Category of Service.**	_ _ _ _
5. Enter a **telephone number** where you can be reached.	(_ _ _) _ _ _ - _ _ _ _
6. Enter numeric portion of **HCPCS code** of enteral being prescribed (B4150, B4151, B4152, B4153, B4154, B4155, or B4156). See the **Enteral Products Classification List** in the February 2004 Medicaid Update, for further information. The system will add the two-digit alpha BO modifier (indicating oral administration) to the HCPCS code, if applicable (shaded area). Products categorized under the **same** HCPCS code must be combined into **one** prior authorization request by the **prescriber**.	B _ _ _ _ [redacted] ***Your claim must match the full five digit or seven digit code on the prior authorization record for payment to be made. The full code is reported to you on the telephone system.***
7. Record caloric units authorized per month (calculated by the telephone system from the prescriber's input of enteral formula calories per day, then divided by 100 and multiplied by 30 days to equal caloric units per month, i.e., a month's supply of formula)	_ _ _ CALORIC UNITS/MONTH
8. Record the authorization activation date (today), number of refills authorized and the prior authorization expiration date. Use the same authorization number for each refill. New authorizations cannot be activated until 10 days prior to expiration date of the existing authorization.	___/___/___ ACTIVATION DATE ___ REFILLS ___/___/___EXP. DATE

CODE	PRODUCT	QUANTITY	PRICE
	ENTERAL FORMULAE AND ENTERAL SUPPLIES (continued)		
B4150	***Enteral formulae; Category I: semi-synthetic intact protein isolates, administered through an enteral feeding tube), (e.g., Enrich, Ensure, Ensure HN, Ensure Powder, Isocal, Lonalac Powder, Meritene, Meritene Powder, Osmolite,Osmolite HN, Portagen Powder, Sustacal, Renu,Sustagen Powder, Travasorb) 100 calories = 1 unit**	up to 600 caloric units/mo	$0.5315 per caloric unit
B4151	***Enteral formulae; Category I: natural intact protein/protein isolates, administered through an enteral feeding tube, (e.g., Compleat B, Vitaneed, Compleat B Modified) 100 calories = 1 unit**	up to 600 caloric units/mo	1.3245 per caloric unit
B4152	***Enteral formulae; Category II: intact protein/protein isolates (calorically dense), administered through an enteral feeding tube, (e.g., Magnacal, Isocal HCN, Sustacal HC, Ensure Plus, Ensure Plus HN) 100 calories = 1 unit**	up to 600 caloric units/mo	0.4046 per caloric unit
B4153	***Enteral formulae; Category III: hydrolyzed protein/amino acids, administered through an enteral feeding tube, (e.g., Criticare HN, Vivonex HN, Vital (Vital HN), Travasorb HN, Isotein HN, Precision HN, EleCare, Precision Isotonic) 100 calories = 1 unit**	up to 600 caloric units/mo	2.0271 per caloric unit
B4154	***Enteral formulae; Category IV: defined formula for special metabolic need, administered through an enteral feeding tube, (e.g., Hepatic-Aid, Travasorb Hepatic, Travasorb MCT, Travasorb Renal, Traum-Aid, Tramacal, Aminaid) 100 calories = 1 unit**	up to 600 caloric units/mo	0.8500 per caloric unit
B4155	***Enteral formulae; Category V: modular components** (protein, carbohydrates, fat), **administered through an enteral feeding tube , (e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose Liquid or Powder, Sumacal, Microlipid, MCT Oil, Nutri-Source) 100 calories = 1 unit**	up to 300 caloric units/mo	2.3000 per caloric unit

NOTE: Products categorized under codes B4154 and B4155 are reimbursable using "By Report" rules when the charge is greater than the price listed.

CODE	PRODUCT	QUANTITY	PRICE
	ENTERAL FORMULAE AND ENTERAL SUPPLIES (continued)		
B4156	***Enteral formulae; Category VI: standardized nutrients, administered through an enteral feeding tube , (Vivonex Std., Travasorb Std., Precision LR and Tolerex) 100 calories = 1 unit**	up to 600 caloric units/mo	$1.2389 per caloric unit
B9998	**Not otherwise classified enteral supplies** (e.g., Liquid Vitamin E, Enfamil AR, Vivonex Flavor Packets)		PA
S8265	**#Haberman feeder for cleft lip/palate**	up to 2/month	15.63
	PARENTERAL FORMULAE AND PARENTERAL SUPPLIES		
B4164	**Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix**		13.26
B4168	**Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - home mix**		18.59
B4172	**Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix**		30.50
B4176	**Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix**		43.22
B4178	**Parenteral nutrition solution; amino acid, greater than 8.5% (500 ml = 1 unit) - home mix**		43.22
B4180	**Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) home mix**		18.30
B4184	**Parenteral nutrition solution; lipids, 10% with administration set (500 ml = 1 unit)**		54.13
B4186	**Parenteral nutrition solution; lipids, 20% with administration set (500 ml = 1 unit)**		74.93
B4189	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix**		84.28
B4193	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix**		140.58
B4197	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix**		158.13
B4199	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix**		229.21

CODE	PRODUCT	QUANTITY	PRICE
	PARENTERAL FORMULAE AND PARENTERAL SUPPLIES (continued)		
B4216	**Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) - home mix, per day**		$11.65
B4220	**Parenteral nutrition supply kit, premix, per day**		PA
B4222	**Parenteral nutrition supply kit, home mix, per day**		PA
B4224	**Parenteral nutrition administration kit, per day**		PA
B5000	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - (Amirosyn RF, Nephramine, Renamine) - premix**		113.37
B5100	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - (Freamine HBC, Hepatamine) - premix**		133.49
B5200	**Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - (branch chain amino acids) - premix**		145.40
B9999	**Not otherwise classified parenteral supplies**		PA

4.3 MEDICAL/SURGICAL SUPPLIES

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	ADHESIVE TAPE/REMOVER			
A4450	**Tape, non-waterproof, per 18 square inches**	(up to 300)	5	$0.06
A4452	**Tape, waterproof, per 18 square inches**	(up to 100)	5	0.11
A4455	**Adhesive remover or solvent (for tape, cement or other adhesive), per ounce**	(up to 40)	5	1.90
	ANTISEPTICS			
A4244	**Alcohol or peroxide, per pint**	473 ml	5	0.99
A4245	**Alcohol wipes, per box**(100's)	each (up to 5)	5	1.43
A4246	**Betadine or pHisoHex solution, per pint**	473 ml (up to 3)	5	2.96
	BREAST PUMPS			

E0602/E0603 include all necessary supplies and collection containers (kit). Rental of hospital grade breast pumps is limited to Durable Medical Equipment vendors.

E0602	**Breast pump, manual, any type**	each (up to 1)	0	17.31
E0603	**#Breast pump, electric (AC and/or DC), any type**	each (up to 1)	0	40.63
	CANES/CRUTCHES/ACCESSORIES			
A4635	**Underarm pad, crutch, replacement, each**	each (up to 2)	0	2.69
A4636	**Replacement, handgrip, cane, crutch or walker, each**	each (up to 2)	0	3.53
A4637	**Replacement, tip, cane, crutch, or walker, each**	each (up to 5)	1	1.64
E0100	**#Cane, includes canes of all materials, adjustable or fixed, with tip**	each (up to 1)	0	12.00
E0105	**#Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips** (over 31" height, no rotation option)	each (up to 1)	0	18.75
E0110	**Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips** (over 23" height, no rotation option)	pair (up to 1)	0	58.93

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	CANES/CRUTCHES/ACCESSORIES (continued)			
E0111	**Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip** (over 23" height,no rotation option)	each (up to 1)	0	$29.46
E0112	**Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips**	pair (up to 1)	0	23.93
E0113	**Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip**	each (up to 1)	0	11.96
E0114	**Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips**	pair (up to 1)	0	23.38
E0116	**Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip**	each (up to 1)	0	11.69
	INCONTINENCE APPLIANCES AND CARE SUPPLIES			
A4310	**Insertion tray without drainage bag and without catheter (accessories only)**	each (up to 30)	5	2.13
A4311	**Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)**	each (up to 30)	5	5.36
A4314	**Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)**	each (up to 30)	5	11.73
A4320	**Irrigation tray with bulb or piston syringe, any purpose**	each (up to 30)	5	1.67
A4322	**Irrigation syringe, bulb or piston, each**	each (up to 50)	5	1.01

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	INCONTINENCE APPLIANCES AND CARE SUPPLIES (continued)			
A4324	**Male external catheter, with adhesive coating, each**	each (up to 60)	5	$1.51
A4325	**Male external catheter, with adhesive strip, each**	each (up to 60)	5	0.96
A4331	**Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each**	each (up to 5)	5	1.80
A4333	**Urinary catheter anchoring device, adhesive skin attachment, each**	each (up to 5)	5	7.83
A4334	**Urinary catheter anchoring device, leg strap, each**	each (up to 12)	5	1.36
A4335	**Incontinence supply; miscellaneous**	up to 1/month		PA
A4338	**Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each**	each (up to 30)	5	1.31
A4344	**Indwelling catheter, Foley type, two-way, all silicone**	each (up to 30)	5	6.13
A4346	**Indwelling catheter, Foley type, three-way for continuous irrigation, each**	each (up to 30)	5	10.11
A4347	**Male external catheter with or without adhesive, with or without anti-reflux device, per dozen**	12's (up to 5)	5	7.50
A4348	**Male external catheter with integral collection compartment, extended wear, (e.g., 2 per month)**	each (up to 2)	5	4.73
A4351	**Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each**	each (up to 250)	5	0.81
A4352	**Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each** (for self-catheterization)	each (up to 250)	5	2.58

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	INCONTINENCE APPLICANCES AND CARE SUPPLIES (continued)			
A4353	**Intermittent urinary catheter, with insertion supplies**	each (up to 60)	5	$3.11
A4354	**Insertion tray with drainage bag but without catheter**	each (up to 30)	5	7.57
	EXTERNAL URINARY SUPPLIES			
A4356	**External urethral clamp or compression device (not to be used for catheter clamp),each**	each (up to 1)	0	39.24
A4357	**Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each**	each (up to 10)	5	3.68
A4358	**Urinary drainage bag; leg or abdomen, vinyl, with or without tube, with straps, each**	each (up to 30)	5	4.13
A4359	**#Urinary suspensory without leg bag, each**	each (up to 1)	0	38.26
	OSTOMY SUPPLIES			
A4361	**Ostomy faceplate, each**	each(up to 15)	5	11.99
A4362	**Skin barrier; solid 4x4 or equivalent, each**	each (up to 25)	5	3.86
A4364	**Adhesive, liquid, or equal, any type, per ounce**	each (up to 20)	5	2.12
A4365	**Adhesive remover wipes, any type, per 50**	each (up to 1)	5	12.35
A4366	**Ostomy vent, any type, each**	each(up to 10)	0	0.86
A4367	**Ostomy belt, each**	each	5	8.53
A4368	**Ostomy filter, any type, each**	each(up to 40)	5	0.30
A4369	**Ostomy skin barrier, liquid (spray, brush, etc.), per oz**	each (up to 22)	5	2.04
A4371	**Ostomy skin barrier, powder, per oz**	each (up to 21)	5	2.49
A4372	**Ostomy skin barrier, solid 4x4 or equivalent, with built-in convexity, each**	each (up to 15)	5	4.19
A4373	**Ostomy skin barrier, with flange (solid, flexible or acccordian), with built-in convexity, any size, each**	each (up to 15)	5	7.11
A4376	**#Ostomy pouch, drainable, with faceplate attached, rubber, each**	each (up to 2)	5	44.03

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	OSTOMY SUPPLIES (continued)			
A4377	**Ostomy pouch, drainable, for use on faceplate, plastic, ea**	each (up to 15)	5	$6.21
A4378	**#Ostomy pouch, drainable, for use on faceplate, rubber, each**	each (up to 2)	5	30.11
A4379	**Ostomy pouch, urinary, with faceplate attached, plastic**	each (up to 15)	5	5.38
A4380	**#Ostomy pouch, urinary, with faceplate attached, rubber, ea**	each (up to 2)	5	47.59
A4381	**Ostomy pouch, urinary, for use on faceplate, plastic, each**	each (up to 10)	5	3.53
A4382	**Ostomy pouch, urinary, for use on faceplate, heavy plastic, each**	each (up to 15)	5	3.53
A4383	**#Ostomy pouch, urinary, for use on faceplate, rubber**	each (up to 2)	5	33.04
A4385	**Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, ea**	each (up to 15)	5	5.35
A4387	**Ostomy pouch closed, with barrier attached, with built-in convexity (1 piece), each**	each (up to 15)	5	3.19
A4388	**Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece) , each**	each (up to 15)	5	3.75
A4389	**Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each**	each (up to 15)	5	6.46
A4390	**Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each**	each (up to 15)	5	8.41
A4391	**Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each**	each (up to 15)	5	6.56
A4392	**Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each**	each (up to 15)	5	10.08
A4393	**Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each**	each (up to 15)	5	10.08
A4394	**Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce**	each (up to 8)	5	2.94

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	OSTOMY SUPPLIES (continued)			
A4395	**Ostomy deodorant for use in ostomy pouch, solid, per tablet**	each (up to 60)	5	$0.19
A4396	**#Ostomy belt with peristomal hernia support**	each (up to 2)	0	40.38
A4397	**Ostomy irrigation supply; sleeve, each**	each (up to 125)	5	2.73
A4398	**Ostomy irrigation supply; bag, each**	each (up to 125)	5	1.00
A4399	**Ostomy irrigation supply; cone/catheter, including brush**	each (up to 1)	5	13.98
A4400	**Ostomy irrigation set**	each (up to 30)	5	30.09
A4402	**Lubricant, per ounce**	(up to 20)	5	0.43
A4404	**Ostomy ring, each**	each(up to 15)	5	1.72
A4405	**Ostomy skin barrier, non-pectin based, paste, per ounce**	each(up to 18)	5	2.36
A4406	**Ostomy skin barrier, pectin-based, paste, per ounce**	each(up to 18)	5	4.66
A4407	**Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each**	each(up to 10)	5	8.69
A4408	**Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each**	each(up to 10)	5	8.64
A4409	**Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each**	each(up to 10)	5	4.80
A4410	**Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each**	each(up to 10)	5	4.80
A4413	**Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each** (used after ostomy surgery)	each(up to 15)	0	6.26

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	OSTOMY SUPPLIES (continued)			
A4414	**Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each**	each(up to 15)	5	$ 4.45
A4415	**Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x4 inches, each**	each(up to 15)	5	4.45
A4416	**Ostomy pouch, closed, with barrier attached, with filter (one piece), each**	each(up to 15)	5	2.61
A4417	**Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each**	each(up to 15)	5	3.16
A4418	**Ostomy pouch, closed; without barrier attached, with filter (one piece), each**	each(up to 15)	5	2.06
A4419	**Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each**	each(up to 15)	5	1.77
A4420	**Ostomy pouch, closed; for use on barrier with locking flange (two piece), each**	each(up to 15)	5	1.55
A4421	**Ostomy supply; miscellaneous**	each(up to 15)	5	PA
A4423	**Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each**	each(up to 15)	5	1.90
A4424	**Ostomy pouch, drainable, with barrier attached, with filter (one piece), each**	each(up to 15)	5	3.15
A4425	**Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each**	each(up to 15)	5	3.61
A4426	**Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each**	each(up to 15)	5	1.68
A4427	**Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each**	each(up to 15)	5	2.55

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	OSTOMY SUPPLIES (continued)			
A4458	**#Enema bag with tubing, reusable**	each (up to 1)	0	$16.26
A5051	**Pouch, closed; with barrier attached (1 piece), each**	each (up to 150)	5	2.48
A5052	**Pouch, closed; without barrier attached (1 piece), each**	each (up to 50)	5	1.96
A5053	**Pouch, closed; for use on faceplate, each**	each (up to 60)	5	2.24
A5054	**Pouch, closed; for use on barrier with flange (2 piece), each**	each (up to 150)	5	1.68
A5055	**Stoma cap**	each	5	2.51
A5061	**Pouch, drainable; with barrier attached (1 piece), each**	each (up to 150)	5	3.37
A5062	**Pouch, drainable; without barrier attached (1 piece), each**	each (up to 150)	5	3.05
A5063	**Pouch, drainable, for use on barrier with flange (2 piece system), each**	each (up to 50)	5	2.27
A5071	**Pouch, urinary; with barrier attached (1 piece), each**	each (up to 50)	5	4.41
A5072	**Pouch, urinary; without barrier attached (1 piece)each**	each (up to 50)	5	4.16
A5073	**Pouch, urinary; for use on barrier with flange (2 piece), each**	each (up to 100)	5	3.34
A5081	**Continent device; plug for continent stoma**	each (up to 5)	5	3.37
A5082	**Continent device; catheter for continent stoma**	each (up to 1)	5	12.12
A5093	**Ostomy accessory; convex insert**	each (up to 5)	5	2.71
	ADDITIONAL INCONTINENCE APPLIANCES/SUPPLIES			
A5105	**#Urinary suspensory; with leg bag, with or without tube**	each (up to 5)	1	75.46
A5112	**Urinary leg bag; latex**	each (up to 5)	5	29.64
A5113	**Leg strap; latex, replacement only, per set**	pair (up to 2 pair)	5	1.86
A5114	**Leg strap; foam or fabric, replacement only, per set**	pair (up to 2 pair)	5	3.92
A5119	**Skin barrier; wipes, 50 per box**	each box (up to 5)	5	9.88

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	ADDITIONAL INCONTINENCE APPLIANCES/SUPPLIES (continued)			
A5121	**Skin barrier; solid, 6x6 or equivalent, each**	each (up to 25)	5	$8.08
A5122	**Skin barrier; solid, 8x8 or equivalent, each**	each (up to 25)	5	15.16
A5126	**Adhesive or non-adhesive; disc or foam pad**	each (up to 30)	5	1.16
A5131	**Appliance cleaner, incontinence and ostomy appliances, per 16 oz.**	each (up to 1)	5	8.06
A5200	**Percutaneous catheter/tube anchoring device, adhesive skin attachment**	each (up to 30)	5	2.70
	COMMODE ACCESSORIES			
E0160	**#Sitz type bath, or equipment, portable, used with or without commode**	each (up to 1)	0	4.49
E0167	**#Pail or pan for use with commode chair**	each (up to 1)	0	5.40
E0275	**Bed pan, standard, metal or plastic**	each (up to 1)	0	3.78
E0276	**#Bed pan, fracture, metal or plastic**	each (up to 1)	0	4.25
E0325	**#Urinal; male, jug-type, any material**	each (up to 1)	0	2.90
E0326	**#Urinal; female, jug-type, any material**	each (up to 1)	0	7.20
	DIABETIC DIAGNOSTICS			
A4250	**Urine test or reagent strips or tablets, (100 tablets or strips)**	each (up to 2)	5	18.36
A4253	**Blood glucose test or reagent strips for home blood glucose monitor,** (visual also), **per 50 strips**	50's (up to 5)	5	39.38
A4254	**#Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each**	each (up to 2)	0	4.65
A4256	**#Normal, low and high calibrator solution/chips**	each (up to 1)	0	8.62
E0607	**#Home blood glucose monitor**	each (up to 1)	0	76.58
E2100	**Blood glucose monitor with integrated voice synthesizer**			PA

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	DIABETIC DAILY CARE			
A4206	**Syringe with needle, sterile 1cc, each**	each (up to 200)	5	$0.20
A4207	**Syringe with needle, sterile 2cc, each**	each (up to 200)	5	0.22
A4208	**Syringe with needle, sterile 3cc, each**	each (up to 200)	5	0.22
A4209	**Syringe with needle, sterile 5cc or greater, each**	each (up to 200)	5	0.31
A4211	**Supplies for self-administered injections** (limited to supplies not otherwise listed)	each	5	PA
A4213	**Syringe, sterile, 20cc or greater, each**	each (up to 200)	5	0.64
A4215	**Needles only, sterile, any size, each**	each (up to 200)	5	0.33
A4230	**#Infusion set for external insulin pump, non needle cannula type**	each (up to 12)	5	13.54
A4231	**#Infusion set for external insulin pump, needle type**	each (up to 24) (two-month supply)	5	5.10
A4232	**#Syringe with needle for external insulin pump, sterile, 3cc**	each (up to 12)	5	4.63
A4244	**Alcohol or peroxide, per pint**	16 oz (up to 5)	5	0.99
A4245	**Alcohol wipes, per box** (100's)	each (up to 5)	5	1.43
A4258	**Spring-powered device for lancet, each**	each (up to 2)	0	12.95
A4259	**Lancets, per box of 100**	each (up to 5)	5	6.06
S8490	**Insulin syringes (100 syringes, any size)** (low dose, 0.3cc - 0.5cc)	100's (up to 2)	5	20.27
S5560	**#Insulin delivery device, reusable pen; 1.5ml size**	up to 1	0	34.98
S5561	**#Insulin delivery device, reusable pen; 3ml size**	up to 1	0	30.66
	FAMILY PLANNING PRODUCTS (See Section 4.1)			
A4266	**Diaphragm for contraceptive use** (kit, e.g., All Flex, Coil, Flat Spring)	each (up to 1)	0	29.53
A4267	**Contraceptive supply, condom, male, each**	each (up to 108)	5	0.39
A4268	**Contraceptive supply, condom, female, each**	each (up to 108)	5	3.00

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	GLOVES			
	Gloves are reimbursable only when medically necessory for recipient. Gloves are not reimbursable as personal protective equipment for employees or when included in a kit or tray (e.g., catheter or tracheostomy). Sterile gloves are only reimburseable when medically necessary.			
A4927	**#Gloves, non-sterile, per 100**	100's(up to 1)	5	$4.55
A4930	**#Gloves, sterile, per pair**	pair, up to 30	5	0.32
	HEAT APPLICATION			
E0210	**#Electric heat pad, standard**	each (up to 1)	0	14.40
E0215	**#Electric heat pad, moist**	each (up to 1)	0	20.93
E0220	**Hot water bottle**	each (up to 1)	0	4.88
E0238	**Non-electric heat pad, moist**	each (up to 1)	0	10.44
	SYNTHETIC SHEEP SKIN AND DECUBITUS CARE			
E0188	**Synthetic sheepskin pad**	each (up to 1)	0	18.75
E0191	**Heel or elbow protector, each**	each(up to 5)	5	2.81
	MASTECTOMY CARE			
L8000	**Breast prosthesis, mastectomy bra**	each (up to 5)	0	31.22
L8001	**Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral**	each (up to 5)	0	93.71
L8002	**Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral**	each (up to 5)	0	123.71
L8020	**Breast prosthesis, mastectomy form**	each (up to 4)	0	180.63
L8030	**Breast prosthesis, silicone or equal**	each (up to 4)	0	180.63
S8460	**Camisole, post-mastectomy**	each (up to 5)	0	37.46
	RESPIRATORY/TRACHEOSTOMY CARE SUPPLIES			
	NOTE: Supplies/parts are for recipient-owned equipment only			
A4481	**Tracheostoma filter, any type, any size, each** (i.e., "artificial nose," heat and moisture exchanger, Thermavent, Humid-vent, Povox stomafilter, Bruce-Foam stomafilter)	each (up to 30)	5	PA

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	RESPIRATORY/TRACHEOSTOMY CARE SUPPLIES (continued)			
NOTE: Code A4609 is not to be billed in conjunction with A4610				
A4609	**Tracheal suction catheter, closed system, for less than 72 hours of use, each** (for mechanical ventilation patient)	each (up to 15)	5	$10.63
A4610	**Tracheal suction catheter, closed system, for 72 or more hours of use, each** (for mechanical ventilation patient)	each (up to 10)	5	10.63
A4614	**Peak expiratory flow meter, hand held**	each (up to 1)	0	19.24
A4615	**Cannula, nasal**	each (up to 4)	5	0.98
A4616	**Tubing, (oxygen), per foot**	each(up to 30)	5	0.80
A4619	**Face tent**	each (up to 4)	5	1.29
A4620	**Variable concentration mask**	each (up to 4)	5	2.29
A4623	**Tracheostomy, inner cannula**	each (up to 5)	5	5.60
A4624	**Tracheal suction catheter, any type, other than closed system,each** (tray)	each (up to 250)	5	1.40
A4625	**Tracheostomy care kit for new tracheostomy**	each (up to 90)	0	4.25
Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30" twill tape, gauze roll and tracheostomy tube holder.				
A4626	**Tracheostomy cleaning brush**	each (up to 2)	0	1.51
A4628	**Oropharyngeal suction catheter, each** (e.g., Yankauer)	each (up to 5)	5	2.02
A4629	**Tracheostomy care kit for established tracheostomy**	each (up to 90)	5	3.08
Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30" twill tape and tracheostomy tube holder.				
A7000	**Canister, disposable, used with suction pump, each**	each (up to 5)	5	4.35
A7002	**Tubing, used with suction pump, each** (suction connection tubes)	each (up to 30)	5	0.92
A7003	**Administration kit, with small volume nonfiltered pneumatic nebulizer, disposable**	each (up to 2)	5	2.25
A7004	**Small volume nonfiltered pneumatic nebulizer, disposable**	each (up to 5)	5	1.29

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	RESPIRATORY/TRACHEOSTOMY CARE SUPPLIES (continued)			
A7005	**#Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable**	each (up to 1)	0	$16.19
A7007	**Large volume nebulizer, disposable, unfilled, used with aerosol compressor**	each (up to 5)	5	2.89
A7013	**Filter, disposable, used with aerosol compressor**	each (up to 5)	5	0.11
A7014	**Filter, non-disposable, used with aerosol compressor or ultrasonic generator**	each (up to 1)	5	0.80
A7015	**Aerosol mask, used with DME nebulizer**	each (up to 1)	5	1.06
A7038	**Filter, disposable, used with positive airway pressure device**	each (up to 5)	0	1.71
A7039	**Filter, nondisposable, used with positive airway pressure device**	each (up to 5)	0	2.40
A7523	**Tracheostomy shower protector, each**	each (up to 1)	2	7.65
A7525	**Tracheostomy mask, each**	each (up to 4)	5	1.68
E0605	**#Vaporizer, room type** (coverable for treatment of respiratory illness; warm or cool mist)	each (up to 1)	0	16.73
S8100	**#Holding chamber or spacer for use with an inhaler or nebulizer; without mask**	each (up to 2)	0	16.50
S8101	**#Holding chamber or spacer for use with an inhaler or nebulizer; with mask**	each (up to 2)	0	27.75
S8189	**Tracheostomy supply, not otherwise classified**	up to 1/month		PA
	SUPPORT GOODS			
A4462	**Abdominal dressing holder, each**	each (up to 5)	0	11.15
A4495	**#Surgical stockings thigh length** (compression 18-35 mmHg)	each (up to 4)	1	14.22
A4500	**#Surgical stockings below knee length** (compression 18-35 mmHg)	each (up to 4)	1	12.41
A4510	**#Surgical stockings full length, each** (e.g., pregnancy support, compression 18-35 mmHg)	each (up to 2)	1	36.39

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	SUPPORT GOODS (continued)			
A4565	**Slings**	each (up to 1)	0	$6.47
A4570	**Splint**	each	5	1.97
L0120	**Cervical, flexible, non-adjustable (foam collar)**	each (up to 1)	0	6.80
L1825	**KO, elastic knee cap, prefabricated, including fitting and adjustment**	each (up to 2)	1	12.41
L1901	**Ankle orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)**	each (up to 2)	1	6.87
L3701	**Elbow orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)**	each (up to 2)	1	8.85
L3909	**Wrist orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)**	each (up to 2)	1	10.86
L3911	**Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g., neoprene, Lycra)**	each (up to 2)	1	11.25
	THERMOMETERS			
A4931	**Oral thermometer, reusable, any type, each**	each(up to 1)	0	1.97
A4932	**Rectal thermometer, reusable, any type, each**	each(up to 1)	0	1.34
	UNDERPADS/DIAPERS			

Diapers and underpads are covered only when medical need may be demonstrated. Diapers will not be covered when incontinence occurs as part of the normal developmental process, i.e., under age three. **The dispenser must maintain documentation of measurements (e.g., waist/hip size, weight) which supports reimbursement for the specific size of diaper dispensed, and may not bill multiple sizes for the same recipient.**

A4335	**Incontinence supply; miscellaneous**	up to 1/month		PA
A4521	**#Adult-sized incontinence product, diaper, small size, each** (waist/hip 20"-34")	each (up to 250)	5	0.47
A4522	**#Adult-sized incontinence product, diaper, medium size, each** (waist/hip 28"-47")	each (up to 250)	5	0.51

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	UNDERPADS/DIAPERS (continued)			
A4523	#Adult-sized incontinence product, diaper, large size, each (waist/hip 40"-59")	each (up to 250)	5	$0.68
A4524	#Adult-sized incontinence product, diaper, extra large size, each (waist/hip >59")	each (up to 250)	5	0.72
A4529	#Child-sized incontinence product, diaper, small/medium size, each (12-23 lbs)	each (up to 250)	5	0.30
A4530	#Child-sized incontinence product, diaper, large size, each (24-35 lbs)	each (up to 250)	5	0.36
A4533	#Youth-sized incontinence product, diaper, each(>35 lbs)	each (up to 250)	5	0.39
A4535	#Disposable liner/shield for incontinence, each	each (up to 250)	5	0.28
A4537	#Underpad, reusable/washable, each	each (up to 6)	0	12.58
A4554	#Disposable underpads, all sizes, (e.g., Chux's)	each (up to 300)	5	0.28
T1500	#Diaper/incontinent pant, reusable/washable, any size, each	each (up to 5)	5	5.31
	WOUND DRESSINGS			
A6010	#Collagen based wound filler, dry form, per gram of collagen	up to 24	5	4.51
A6011	#Collagen based wound filler, gel/paste, per gram of collagen	up to 27	5	3.86
A6021	#Collagen dressing, pad size 16 sq. in. or less, each	up to 5	5	19.88
A6022	#Collagen dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each	up to 5	5	38.50
A6023	#Collagen dressing, pad size more than 48 sq. in., each	up to 5	5	76.88
A6024	#Collagen dressing wound filler, per 6 inches	up to 16	5	11.50
A6196	Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing	up to 20	5	5.50

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6197	**Alginate or other fiber gelling dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., each dressing**	up to 20	5	$6.43
A6198	**Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing**	up to 10	5	14.52
A6199	**Alginate or other fiber gelling dressing, wound filler, per 6 inches**	up to 20	5	2.76
A6200	**Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 20	5	1.58
A6201	**Composite dressing, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 20	5	2.70
A6203	**Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 20	5	2.11
A6204	**Composite dressing, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 20	5	4.09
A6205	**Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 10	5	5.65
A6206	**Contact layer, 16 sq. in., or less, each dressing**	up to 20	5	1.53
A6207	**Contact layer, more than 16 but less than or equal to 48 sq. in., each dressing**	up to 20	5	2.68
A6208	**Contact layer, more than 48 sq. in., each dressing**	up to 10	5	6.50
A6209	**Foam dressing, wound cover, pad size 16 sq. in, or less, without adhesive border, each dressing**	up to 20	5	1.66

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6210	**Foam dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 20	5	$3.57
A6211	**Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 20	5	8.09
A6212	**Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 20	5	3.99
A6213	**Foam dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 20	5	9.06
A6214	**Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 10	5	17.59
A6216	**Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 100	5	0.04
A6217	**Gauze, non-impregnated, non-sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 100	5	0.08
A6218	**Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 25	5	0.19
A6219	**Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 100	5	0.22
A6220	**Gauze, non-impregnated, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 30	5	1.08

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6221	Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing	up to 10	5	$2.42
A6222	Gauze, impregnated, other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	up to 30	5	1.44
A6223	Gauze, impregnated, other than water, normal saline, or hydrogel, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing	up to 50	5	1.71
A6224	Gauze, impregnated, other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing	up to 12	5	1.79
A6228	Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing	up to 30	5	1.62
A6229	Gauze, impregnated, water or normal saline, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing	up to 30	5	1.69
A6230	Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing	up to 30	5	1.82
A6231	Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, each dressing	up to 30	5	1.32
A6232	Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. in. but less than or equal to 48 sq. in., each dressing	up to 30	5	4.01
A6233	Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., each dressing	up to 30	5	5.57

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6234	**Hydrocolloid dressing, wound cover pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30	5	$5.69
A6235	**Hydrocolloid dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in. without adhesive border, each dressing**	up to 30	5	11.26
A6236	**Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30	5	13.88
A6237	**Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30	5	5.07
A6238	**Hydrocolloid dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in. with any size adhesive border, each dressing**	up to 30	5	7.73
A6239	**Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 30	5	10.54
A6240	**Hydrocolloid dressing, wound filler, paste, per fluid ounce**	up to 20	5	7.88
A6241	**Hydrocolloid dressing, wound filler, dry form, per gram**	up to 25	5	1.54
A6242	**Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30	5	3.06
A6243	**Hydrogel dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 30	5	6.49
A6244	**Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30	5	14.05

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6245	**Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30	5	$3.56
A6246	**Hydrogel dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adnesive border, each dressing**	up to 30	5	7.39
A6247	**Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 30	5	18.77
A6248	**Hydrogel dressing, wound filler, gel, per fluid ounce**	up to 30	5	4.16
A6251	**Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 20	5	2.13
A6252	**Specialty absorptive dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 20	5	2.54
A6253	**Specialty absorptive dressing wound cover, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 20	5	3.61
A6254	**Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 20	5	1.07
A6255	**Specialty absorptive dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 20	5	1.71
A6256	**Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 20	5	3.85
A6257	**Transparent film, 16 sq. in. or less, each dressing**	up to 30	5	0.35
A6258	**Transparent film, more than 16 but less than or equal to 48 sq. in., each dressing**	up to 30	5	1.16

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6259	Transparent film, more than 48 sq. in., each dressing	up to 30	5	$2.46
A6261	Wound filler, gel/paste, per fluid ounce, not elsewhere classified	up to 20	5	PA
A6262	Wound filler, dry form, per gram, not elsewhere classified	up to 20	5	PA
A6266	Gauze, impregnated, other than water, normal saline, or zinc paste, any width, per linear yard	up to 20	5	2.01
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less without adhesive border, each dressing	up to 100	5	0.13
A6403	Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing	up to 100	5	0.25
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	up to 25	5	0.35
A6407	Packing strips, non-impregnated, up to two inches in width, per linear yard	up to 30	5	1.91
A6410	Eye pad, sterile, each	up to 50	5	0.23
A6411	Eye pad, non-sterile, each	up to 50	5	0.16
A6412	Eye patch, occlusive, each	up to 30	5	0.27
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	up to 30	5	2.30
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	up to 90	5	0.04
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	up to 90	5	0.06

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6444	**Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard**	up to 90	5	$0.08
A6445	**Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard**	up to 90	5	0.06
A6446	**Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard**	up to 90	5	0.10
A6447	**Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard**	up to 90	5	0.18
A6448	**Light compression bandage, elastic, knitted/woven, width less than three inches, per yard**	up to 90	5	0.06
A6449	**Light compression bandage, elastic, knitted/woven, width greater than or equal to three iches and less than five inches, per yard**	up to 90	5	0.09
A6450	**Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard**	up to 90	5	0.16
A6451	**Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard**	up to 90	5	0.17
A6452	**High compression bandage, elastic, knitted/woven load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard**	up to 15	5	1.22

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	WOUND DRESSINGS (continued)			
A6453	**Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard**	up to 30	5	$0.40
A6454	**Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard**	up to 30	5	0.57
A6455	**Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard**	up to 30	5	0.68
	VARIOUS MISCELLANEOUS			
A4216	**Sterile water/saline, 10ml**	up to 120	5	0.35
A4217	**Sterile water/saline, 500ml**	up to 10	5	1.58
A4221	**#Supplies for maintenance of drug infusion catheter, per week (list drug separately)** (bill monthly)	each unit (up to 40 units per month)	5	1.00
Use for all supplies necessary for maintenance of drug infusion catheters and external pumps, and/or supplies necessary for the administration of drugs (except insulin) not otherwise listed in the fee schedule				
A4305	**Disposable drug delivery system, flow rate of 50ml or greater per hour**	once/month	5	PA
A4306	**Disposable drug delivery system, flow rate of 5ml or less per hour**	once/month	5	PA
A4649	**Surgical supply; miscellaneous**	once/month	5	PA
A4660	**#Sphygmomanometer/blood pressure apparatus with cuff and stethoscope, kit, any type**	up to 1	0	20.59
A9999	**Miscellaneous DME supply or accessory, not otherwise specified**	once/month	5	PA
E0710	**Restraints, any type (body, chest, wrist or ankle)**	each (up to 4)	0	13.65
K0552	**#Supplies for external drug infusion pump, syringe type cartridge, sterile, each**	up to 30	5	2.65

CODE	PRODUCT	QUANTITY/SIZE	REFILLS	PRICE
	VARIOUS MISCELLANEOUS (continued)			
T5999	**Supply, not otherwise specified,** limited to the following previously state-defined codes:			
Z2003	**Plastic strips**	50's (up to 5)	0	$2.81
Z2110	**Low profile tube/button/port kit** (for recipients who cannot tolerate the size of a standard gastrostomy tube or who have experienced failure of a standard gastrostomy tube. This kit includes tube/button/port, syringes, extension and/or decompression tubing and obturator if indicated.)	up to 1/3 months	5	114.58
Z2351	**Basal thermometer**	each (up to 1)	0	10.41
Z2156	**Sterile 6" wood applicator w/cotton tips**	100's (up to 1)	0	2.74
Z2640	**Incentive spirometer**	each (up to 1)	0	5.88
Z2744	**Nasal aspirator**	each (up to 1)	0	2.54

4.4 HEARING AID BATTERY

CODE	PRODUCT	QUANTITY/SIZE	PRICE
V5266	**Battery for use in hearing device** (any type)	each	0.75

NOTE: To be priced by the State on a periodic basis at retail less 20 percent. When billing for batteries on the claim form the "Quantity Dispensed" field refers to the individual number of batteries dispensed not number of packages dispensed.

4.5 COMPOUNDED PRESCRIPTIONS

Claims for compounded prescriptions must be submitted using one of the following two options that be came effective February 18, 2004. Reconstitution of a commercially available product is not considered compounding.

A compound is considered reimbursable only when the compound includes:

- A combination of any two or more legend drugs found on the List of Medicaid Reimbursable Drugs; or
- A combination of any legend drug(s) included on the List of Medicaid Reimbursable drugs and any other item(s) not commercially available as an ethical or proprietary product, or
- A combination of two or more products which are labeled: "Caution: For Manufacturing Purpose only."

Option 1 - Billing for Individual Components by NDC Number using NCPDP 3.2 or 5.1

- This option must be used when billing compounded controlled substances to comply with the Bureau of Controlled Substances standards.
- Submit claims for compounded prescriptions using the NDC code for each ingredient. These claims are eligible for the Electronic Claim Capture (ECC) option when submitted through the NCPDP format.
- Each ingredient must have a unique prescription number.
- For on-line submitted claims, NCPDP Compound Code Field (406-D6) must contain a value of 1.
- Each drug ingredient payable by New York Medicaid will be reimbursed at AWP-12% plus a dispensing fee: $3.50 (if a brand drug) or $4.50 (if a generic drug).
- Payment will only be made for NDCs covered on the List of Medicaid Reimbursable Drugs.

OR

Option 2 — Billing for a Compound as a Single Entity using NCPDP 5.1

- The entire prescription must have one unique prescription number.
- For on-line claims capture, Compound Code Field (406-D6) must contain a value of 1.
- In the Product Service ID Field (407-D7), enter NDC Code using all "9's".
- In the Product/Service ID Qualifier Field (436-E1) a value of 03 must be entered.
- A value of 1 must be entered in the Quantity Field.
- Reimbursement for each compound prescription billed using Option 2 is restricted to the usual and customary price charged to the general public for the total sum of the ingredients, up to the maximum reimbursable amount (MRA) for this option ($50.00), plus a dispensing fee of $3.50 and a compounding fee of $0.75.
- There is no co-payment assessed using this option.
- The pharmacy must retain the prescription and documentation of ingredients, amounts and costs.

INQUIRY

5.0 INQUIRY

This Provider Inquiry Section has been updated and is intended to assist you in your search for further information. Please include your MMIS Provider ID number when making inquiries and in all correspondence.

For Questions Concerning:	Contact:
OBTAINING CLAIM FORMS ORDERING PROVIDER MANUALS AND UPDATES PREPARING/COMPLETING CLAIM FORMS PROVIDER RELATIONS ISSUES REMITTANCE STATEMENTS/BILLING CONCERNS TAPE/DISKETTE SUBMISSIONS TRAINING/BILLING SEMINARS	COMPUTER SCIENCES CORPORATION (Contact your appropriate billing unit) *Institutional Services (518) 447-9810 (800) 522-1892 *Practitioner Services (518) 447-9860 (800) 522-5518 *Professional Services (518) 447-9830 (800) 522-5535 *For List of Provider Types, see page 5-2
CHECK AMOUNTS (To obtain check amounts prior to the release of the check, select Check Call option from the menu of services offered. There is a charge of $.85 per minute for this optional service. Only the current week's check amount will be reported. This information will be available after 12:00 p.m. of the first business day of the week and will remain available all day.)	NYS DEPARTMENT OF HEALTH 1-900-555-2525
TO REQUEST PRIOR APPROVAL FORMS	Computer Sciences Corporation P.O. Box 4401 Albany, New York 12204-0401
TO REQUEST UTILIZATION THRESHOLD OVERRIDE APPLICATIONS	Computer Sciences Corporation MOAS P.O. Box 4420 Albany, New York 12204-0420 (518) 426-5843 (800) 421-3893
TO SUBMIT PAPER CLAIMS	Computer Sciences Corporation P.O. Box 4444 Albany, New York 12204-0444
TO SUBMIT TAPE/DISKETTE CLAIMS	Computer Sciences Corporation 800 North Pearl Street, 1st Floor Albany, New York 12204 Attention: Input Control

PROVIDER TYPES

INSTITUTIONAL SERVICES:	PRACTITIONER SERVICES:
- Assisted Living Program - Child Care - Clinic - Comprehensive Medicaid Case Management - Day Treatment - Dental Clinic - Health Maintenance Organization - Home and Community Based Services Waivers • Care at Home Program • Long Term Home Health Care Program • OMH Children's Waiver • OMRDD Waiver • TBI Waiver - Home Health - Hospice - ICF DD - Inpatient - Laboratory (Hospital) - Limited Licensed Home Care Services Agency - Nursing Service (Registry) - Office of Mental Health Certified Rehabilitation Services - Ordered Ambulatory - Personal Care - Personal Emergency Response Services - Residential Health Care Facility (Nursing Home) - School Supportive Health Services	- Chiropractor (QMB Services) - Clinical Psychologist - Clinical Social Worker (QMB Services) - Dental - Midwife - Nurse Practitioner - Nursing Services - Ophthalmic - Physician - Podiatry - Portable X-ray Supplier (QMB Services) - Rehabilitation Services PROFESSIONAL SERVICES: (BUSINESSES) - DME - Hearing Aid - Laboratory - Pharmacy - Transportation

For Questions Concerning:	Contact:
MEDICAID POLICY	NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF MEDICAID MANAGEMENT
Call Center Help Line	1-800-541-2831
Co-Pay Hotline	1-800-541-2831
Fraud/Forgery Hotline	1-877-873-7283
Medical/Dental Prior Approval	1-800-342-3005
Restricted Recipients	1-518-474-6866
OBTAINING TRANSPORTATION PRIOR APPROVAL	
NYC	1-800-243-7842
Upstate	Local Social Services District, see page 5-10.
OBTAINING PERSONAL CARE SERVICES PRIOR APPROVAL	Local Social Services District, see page 5-10
OBTAINING DIAGNOSIS CODES	
Copies may be purchased from two sources:	International Classification of Diseases ICD-9-CM P.O. Box 991 Ann Arbor, MI 48106 Superintendent of Documents US Government Printing Office Washington, DC 20402
FORMS	
DSS-3113 - Hysterectomy Receipt of Information	Office of Temporary and Disability Assistance Forms & Print Management P.O. Box 1990 Albany, New York 12201
DSS-3134 - Sterilization Consent	
DSS-3559 - Long Term Care Facility Report of Medicaid Recipient Admission/Readmission or Discharge/Transfer Form	

For Questions Concerning:	Contact:
RECIPIENT ELIGIBILITY	
Recipient eligibility status and coverage can be verified via the Medicaid Eligibility Verification System (MEVS). To access the verification system, the provider will need to follow the instructions in the MEVS Provider Manual.	The MEVS Manual can be obtained by calling Computer Sciences Corporation at the appropriate number for your provider type, see page 5-1.
Assistance with the MEVS verification procedures or VeriFone terminal equipment can be obtained by calling the MEVS Provider Services toll-free number. This number is for providers only.	MEVS PROVIDER SERVICES 1-800-343-9000
Eligibility discrepancies must be reported to the recipients' Local Social Services Districts. MEVS staff cannot address these calls or resolve eligibility file issues.	Local District Listing, see page 5-10.
Assistance can be obtained when the provider believes that a patient is covered by Medicaid, but does not have the patient's Medicaid number by calling this telephone number and selecting Name Search option from the menu of services offered. There is a charge of $.85 per minute for this optional service. A touch tone telephone is required.	NEW YORK STATE DEPARTMENT OF HEALTH 1-900-555-2525

For Questions Concerning:	Contact:
PROVIDER ENROLLMENT, CHANGE OF INFORMATION, OWNERSHIP CHANGE, ADD OR CHANGE LOCATOR CODES If you are: Audiologist Chiropractor Dental Group Dental School Dentist DME Supplier Hearing Aid Dispenser Laboratory Laboratory Director Multi Service Group Midwife Nurse Nurse Practitioner Nurse Registry Optician Optometrist Pharmacy Physician Physician Assistant Podiatrist/Group Portable X-ray Supplier Psychologist/Group Service Bureau Shared Health Facility Social Worker/Group Therapist/Group Transportation Provider	Fee for Service Provider Enrollment Bureau of Medical Review and Payment Office of Medicaid Management New York State Department of Health 150 Broadway, Suite 6E Albany, New York 12204-2736 (518) 486-9440 (518) 473-7251 (Fax)
If you are: Assisted Living Program Case Management Adult Day Care Program Child Care Agency Clinic Community Residence Diagnostic and Treatment Center Emergency Room HCBS/TBI Waiver Provider Home Health Agency Hospice HMO Hospital Intermediate Care Facility for Mentally Retarded Long Term Home Health Care Program Nursing Facility Personal Care Provider Personal Emergency Response System Provider Prepaid Capitation Group School Supportive Health Service	Rate Based Provider Unit Bureau of Medical Review and Payment Office of Medicaid Management New York State Department of Health 150 Broadway, Suite 6E Albany, New York 12204-2736 (518) 474-8161
CLAIMS OVER TWO YEARS OLD	Pended Claims Bureau of Medical Review and Payment Office of Medicaid Management New York State Department of Health 150 Broadway, Suite 6E Albany, New York 12204-2736 (518) 473-4029

DOH DIRECTORY ONLINE (Contains many toll-free numbers and web addresses)	www.health.state.ny.us
LIST OF DISQUALIFIED ORDERERS OF MEDICAID SERVICES	www.health.state.ny.us/nysdoh/medicaid/medicaid.htm
MEDICAID UPDATE MONTHLY NEWSLETTERS	www.health.state.ny.us/nysdoh/mancare/omm/main.htm
PUBLIC HEALTH FORUM NYS Health Rules and Regulations Full Text Search – Official Compilation of NY Codes, Rules and Regulations (NYCRR)	Title 10 – NYCRR www.health.state.ny.us/nysdoh/phforum/nycrr10.htm Title 18- NYCRR www.health.state.ny.us/nysdoh/phforum/nycrr18.htm
DOH DIRECTORY SERVICES:	TOLL FREE HELP LINE NUMBERS:
CHILD HEALTH PLUS	1-800-698-4KIDS
EPIC - ELDERLY PHARMACEUTICAL INSURANCE COVERGE PROGRAM	1-800-634-1340
FAMILY HEALTH PLUS PROGRAM	1-877-9-FHPLUS (1-877-934-7587)
OFFICE OF MANAGED CARE PROGRAM	1-800-206-8125
OFFICE OF PROFESSIONAL MEDICAL CONDUCT (Complaints and Inquiries)	1-800-663-6114
SMOKERS QUITLINE	1-888-609-6292
NDC OR LEGEND DRUG QUESTIONS (Should a problem occur concerning an NDC number or price of a legend drug on the New York State microfiche)	NYS Department of Health Office of Medicaid Management 99 Washington Avenue, Suite 606 Albany, New York 12210-2806 Attention: Mark Richard-Butt Director of Pharmacy Policy and Operations (518) 486-3209

PRIOR APPROVAL AND MEDICAL REVIEW INFORMATION

The verification process via MEVS must be completed to determine the County having financial responsibility for the recipient; consult the list below for the appropriate offices to contact.

Area Office	Recipient's County of Fiscal Responsibility
New York City Department of Health **Bureau of Health Insurance Services** 161 William Street, 6th FLR, Box 34 New York, NY 10038 (212) 676-2950 **Transportation** (CSC) (800) 243-7842	Bronx Kings (Brooklyn) New York (Manhattan) Queens Richmond (Staten Island)
New York State Department of Health **Metropolitan Regional Office** Medical Prior Approval Unit 5 Penn Plaza New York, NY 10001 (212) 268-6645 for: **Durable Medical Equipment**	Bronx Dutchess Kings (Brooklyn) Nassau New York (Manhattan) Orange Putnam Queens Richmond (Staten Island) Rockland Suffolk Sullivan Ulster Westchester
New York State Department of Health **Buffalo Area Office** 584 Delaware Avenue Buffalo, New York 14202 (800) 462-8407 for: **Durable Medical Equipment** **Out-of-State Services** **Pharmacy** (800) 462-7552, (716) 847-4650 (except Enteral products listed under code B9998) Private Duty Nursing (except Erie County)	Allegany Cattaraugus Chautauqua Erie Genesee Niagara Orleans Wyoming

5.0 INQUIRY (Cont'd)

PRIOR APPROVAL AND MEDICAL REVIEW INFORMATION (Cont'd)

Area Office	Recipient's County of Fiscal Responsibility
Prior Approval Bureau of Medical Review & Payment Office of Medicaid Management New York State Department of Health 150 Broadway, Suite 6E Albany, New York 12204-2736 (518) 474-3575 (800) 342-3005 for: Dental (including Medicaid orthodontic prior approval for Westchester County recipients only) Dispensing Validation System (DVS) and Voice Interactive Telephone Prior Authorization System for non-drug items.(Requests for override of frequency/ quantity limits for medical reasons only) Eye Services Hearing Aids Physician	STATEWIDE
Durable Medical Equipment	STATEWIDE – Except for Buffalo & Metropolitan Regional Areas
Out-of-State Services Pharmacy (including Enteral products listed under code B9998 for Buffalo Area).	STATEWIDE – Except for Buffalo Area
Private Duty Nursing Services Broome County Broome County Department of Social Services Medical Services Unit 36-42 Main Street Binghamton, New York 13905 (607) 778-2707 Chemung County Chemung County Human Resources Center 425-447 Pennsylvania Avenue Elmira, New York 14904 (607) 737-5487 Erie County Erie County Department of Social Services Erie County C.A.S.A. 95 Franklin Street Buffalo, New York 14202 (716) 858-2375	STATEWIDE – Except for the seven counties listed, and those in the Buffalo Area.

PRIOR APPROVAL AND MEDICAL REVIEW INFORMATION (Cont'd)

Area Office	Recipient's County of Fiscal Responsibility
Oneida County Oneida County Department of Social Services Oneida County Office of Continuing Care 520 Seneca Street, 2nd Floor Utica, New York 13502 (315) 798-5456 Schenectady County Schenectady County Department of Social Services 107 Nott Terrace, 3rd Floor Schenectady, New York 12308 (518) 386-2253 Tompkins County Tompkins County Department of Social Services Tompkins County Long Term Care 320 West State Street Ithaca, New York 14850 (607) 274-5278 Westchester County Westchester County Department of Social Services Division of Medical Home Care Services 270 North Avenue New Rochelle, NY 10801 (914) 813-5440	

LOCAL SOCIAL SERVICES DISTRICTS

Albany County Department of Social Services
162 Washington Avenue
Albany, New York 12210
(518) 447-7300

Allegany County Department of Social Services
7 Court Street
Belmont, New York 14813
(585) 268-9622

Broome County Department of Social Services
36-38 Main Street
Binghamton, New York 13905-3199
(607) 778-8850

Cattaraugus County Department of Social Services
1701 Lincoln Avenue, Suite 4010
Olean, New York 14760-1158
(716) 373-8070

Cayuga County Department of Social Services
County Office Building
160 Genesee Street
Auburn, New York 13021-3433
(315) 253-1011

Chautauqua County Department of Social Services
Hall R. Clothier Health & Social Services Building
Mayville, New York 14757
(716) 753-4421

Chemung County Department of Social Services
Human Resources Center
425-447 Pennsylvania Avenue
Elmira, New York 14904-1795
(607) 737-5309

Chenango County Department of Social Services
County Office Building
Court Street
Norwich, New York 13815
(607) 337-1500

Clinton County Department of Social Services
13 Durkee Street
Plattsburgh, New York 12901
(518) 565-3300

Columbia County Department of Social Services
25 Railroad Avenue
P.O. Box 458
Hudson, New York 12534-2514
(518) 828-9411

Cortland County Department of Social Services
County Office Building
P.O. Box 5590
60 Central Avenue
Cortland, New York 13045-5590
(607) 753-5248

Delaware County Department of Social Services
111 Main Street
Delhi, New York 13753-1265
(607) 746-2325

Dutchess County Department of Social Services
60 Market Street
Poughkeepsie, New York 12601-3302
(845) 486-3000

Erie County Department of Social Services
95 Franklin Street, Room 828
Buffalo, New York 14202-3959
(716) 858-8000

Essex County Department of Social Services
100 Court Street, P.O. Box 217
Elizabethtown, New York 12932-0217
(518) 873-3302

Franklin County Department of Social Services
Court House
Malone, New York 12953
(518) 483-6770

Fulton County Department of Social Services
County Building
P.O. Box 549
Johnstown, New York 12095
(518) 736-5640

Genesee County Department of Social Services
County Office Building #2
3837 West Main Street
Batavia, New York 14020-9407
(585) 344-2580

LOCAL SOCIAL SERVICES DISTRICTS

Greene County Department of Social Services
465 Main Street
P.O. Box 528
Catskill, New York 12414-1716
(518) 943-3200

Hamilton County Department of Social Services
Court House
P.O. Box 725 - White Birch Lane
Indian Lake, New York 12842-0725
(518) 648-6131

Herkimer County Department of Social Services
301 North Washington Street, Suite 2110
Herkimer, New York 13350
(315) 867-1291

Jefferson County Department of Social Services
Human Services Building
250 Arsenal Street
Watertown, New York 13601
(315) 782-9030

Lewis County Department of Social Services
Outer Stowe Street
P.O. Box 193
Lowville, New York 13367
(315) 376-5400

Livingston County Department of Social Services
Livingston County Campus, Building 3
Mount Morris, New York 14510
(585) 243-7300

Madison County Department of Social Services
P.O. Box 637
Wampsville, New York 13163
(315) 366-2211

Monroe County Department of Social Services
111 Westfall Road, Room 660
Rochester, New York 14692-4686
(585) 274-6000

Montgomery County Department of Social Services
County Office Building
Fonda, New York 12068
(518) 853-4646

Nassau County Department of Social Services
County Seat Drive
Mineola, New York 11501
(516) 571-4444

New York City Human Resources Administration
180 Water Street
New York, New York 10038
(212) 331-6230

Niagara County Department of Social Services
100 Davidson Road, P.O. Box 506
Lockport, New York 14095-3394
(716) 439-7602

Oneida County Department of Social Services
County Office Building
800 Park Avenue
Utica, New York 13501-2981
(315) 798-5733

Onondaga County Department of Social Services
Onondaga County Civic Center
421 Montgomery Street
Syracuse, New York 13202-2923
(315) 435-2985 or (315) 425-2986

Ontario County Department of Social Services
3010 County Complex Drive
Canandaigua, New York 14424
(585) 396-4060

Orange County Department of Social Services
Quarry Road, Box Z
Goshen, New York 10924-0678
(845) 291-4000

Orleans County Department of Social Services
14016 Route 31 West
Albion, New York 14411-9365
(585) 589-7004

Oswego County Department of Social Services
County Office Building, Spring Street
Mexico, New York 13114
(315) 963-5000

LOCAL SOCIAL SERVICES DISTRICTS

Otsego County Department of Social Services
County Office Building
197 Main Street
Cooperstown, New York 13326-1196
(607) 547-4355

Putnam County Department of Social Services
110 Old Route Six Center
Building #2
Carmel, New York 10512-2110
(845) 225-7040

Rensselaer County Department of Social Services
133 Bloomingrove Drive
Troy, New York 12180-8403
(518) 283-2000

Rockland County Department of Social Services
Building L
Sanatorium Road
Pomona, New York 10970
(845) 364-2000

St. Lawrence County Department of Social Services
Harold B. Smith Building
6 Judson Street
Canton, New York 13617-1197
(315) 379-2111

Saratoga County Department of Social Services
152 West High Street
Ballston Spa, New York 12020
(518) 884-4140

Schenectady County Department of Social Services
487 Nott Street
Schenectady, New York 12308-1812
(518) 388-4470

Schoharie County Department of Social Services
County Office Building
P.O. Box 687
Schoharie, New York 12157
(518) 295-8334

Schuyler County Department of Social Services
County Office Building
105 Ninth Street
Watkins Glen, New York 14891
(607) 535-8303

Seneca County Department of Social Services
1 DiPronio Drive
Waterloo, New York 13165-0690
(315) 539-1800

Steuben County Department of Social Services
3 East Pulteney Square
Bath, New York 14810
(607) 776-7611

Suffolk County Department of Social Services
3085 Veterans Memorial Highway
Ronkonkoma, New York 11779
(631) 854-9700

Sullivan County Department of Social Services
Box 231, 16 Community Lane
Liberty, New York 12754
(845) 292-0100

Tioga County Department of Social Services
Box 240 Route 38
Owego, New York 13827
(607) 687-8300

Tompkins County Department of Social Services
320 West State Street
Ithaca, New York 14850
(607) 274-5336

Ulster County Department of Social Services
1061 Development Court
Kingston, New York 12401
(845) 334-5000

Warren County Department of Social Services
Warren County Municipal Center
Lake George, New York 12845
(518) 761-6300

Washington County Department of Social Services
Washington Municipal Center
383 Broadway
Fort Edward, New York 12828
(518) 746-2300

LOCAL SOCIAL SERVICES DISTRICTS

Wayne County Department of Social Services
77 Water Street
P.O. Box 10
Lyons, New York 14489-0010
(315) 946-4881

Westchester County Department of Social Services
County Office Building #2
112 East Post Road
White Plains, New York 10601-5272
(914) 995-5000

Wyoming County Department of Social Services
466 North Main Street
Warsaw, New York 14569-1080
(585) 786-8900

Yates County Department of Social Services
County Office Building
110 Court Street
Penn Yan, New York 14527-1118
(315) 536-5183

GLOSSARY

6.0 GLOSSARY

Adjustment	A transaction initiated by the Provider which changes one or more fields of a previously paid claim.
Aid Category	A designation within SSI or the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Benefits	Services which are covered and paid for by the Medicare (Title XVIII) program.
BNDD	Bureau of Narcotics and Dangerous Drugs (now known as DEA - Drug Enforcement Agency).
CHAP	Child Health Assurance Program - A Program of ongoing and comprehensive primary health care for Medicaid eligible children. This program incorporates early, periodic screening, as well as diagnosis and treatment for these children from birth to 21 years of age. (Same as EPSDT.)
Claim	A request for payment of services rendered to a Recipient which the Provider sends to Medicaid.
Claim Reference Number	The unique number assigned by the Fiscal Agent to a claim, and which appears in Column 3 on the Remittance Statement.
Crossover Claim	A bill for services rendered to a Recipient receiving benefits from both Medicare and Medicaid, where Medicare pays first and then determines amount of unmet Medicare deductible and co-insurance to be paid by Medicaid.
DEA	Drug Enforcement Agency (Previously BNDD).
DEA Number	Number of the license issued by DEA to physicians allowed to prescribe dangerous drugs and narcotics.

Deny Denied Claim	To determine that a claim will not be paid because it does not conform to program limitations or because errors have been identified (example: Recipient is not eligible).
Disability	The inability to engage in any substantial or gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.
Dispensing Fee	A professional fee paid to pharmacies.
DMA	Division of Medical Assistance.
DOH	Department of Health.
Dosage Form	The actual form a substance is in when dispensed, i.e., capsule, suppository, etc.
DSS	Department of Social Services - the New York State agency which has been designated as the single state agency for general overall administration of the Title XIX (Medicaid) Program in New York State.
Emergency	Care for patients with severe, life-threatening or potentially disabling conditions which require immediate intervention.
EOMB or EOB	Explanation of Medical Benefits - an explanation of services periodically issued to Recipients on whose behalf claims have been paid.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment. This Federal program provides medical services for individuals under 21. (CHAP is the NYS version of EPSDT.)
Family Planning Services	These include diagnosis, treatment, drugs, supplies and related counseling which are furnished or prescribed by, or are under the supervision of the physician. The services include, but are not limited to: physician, clinic, or hospital visits during which birth control pills are prescribed; periodic examinations associated with a contraceptive method; visits during which sterilization, other methods of birth control, or procedures to promote fertility are discussed.

Field	This is the space, box or line in which a particular item of information would be written on a claim form or other preprinted document.
Fiscal Agent	An organization under contract to the State to process claims for a State Medicaid Program.
Generic	A generic drug is a drug marketed under a non-proprietary name, (the accepted chemical name and not a trade name).

Example:	Trade Name		Generic Name
	Tylenol	=	Acetaminophen
	Valium	=	Diazepam

HMO	Health Maintenance Organization. A private health organization which provides medical care to enrolled individuals on a fixed, periodic, prepayment basis. These facilities are responsible for providing most health and medical services to their enrollees and are usually prepaid group practices.
Home Health Care	Medically necessary skilled nursing services which are available to eligible Medicaid recipients in their homes.
Invoice	A form containing one or more claim lines (also called a claim form).
Legend Drug	See Prescription drug.
Medically Indigent	A term used to describe persons in need of financial assistance and/or whose income and resources will not allow them to pay for the costs of medical care. (Also called categorically needy.)
Medicaid	(Title XIX of the Social Security Act) A federally aided but State operated and administered program which provides medical benefits for certain low-income persons in need of health and medical care.

Medicare	(Title XVIII) A hospital and medical health insurance program for people aged 65 and over, for persons eligible for social security disability payments, and for certain others. Health care is available to these persons without regard to income.
NDC	National Drug Code.
OTC	Over-the-counter drug (see Non-Legend).
Outpatient Care	Services and procedures rendered to a Recipient who receives treatment from the facility and departs on the same day, (i.e., the patient does not require hospitalization or institutionalization).
Participant	One who participates in the Medicaid Program either as a Provider of health care services or as a Recipient.
Payment Cycle	The computerized process by which payment is generated for approved claims. The Remittance Statement and payment check are products of the Payment Cycle.
Pend/Pended Claims	A claim which is suspended by the Claims Processing System and which is manually reviewed. Such claims are ultimately either cleared for payment or denied.
PHCP	Physically Handicapped Children's Program: A federal grant program which is supervised by the NYS Department of Health for the treatment and rehabilitation of physically handicapped children.
Price	Amount paid for drug or supply.
Prior Approval	The evaluation of a prescriber's request for a specific service to determine the medical necessity and appropriateness of the care requested for a Recipient. The approval process is performed by the Reviewing Health Professional (DOH) who is in turn responsible to the DSS for his decision.

Provider	A person, organization or institution enrolled and certified to provide health care services authorized under the State Medicaid Program.
Recipient	A person certified by his/her local Welfare Department to receive the benefits of Medicaid under one of the designated categories.
Reject Rejected Claim	To return a claim to a Provider for a correction or change that will allow it to be processed properly. Claims are rejected for omissions or errors in the information on the claim form.
Remittance Statement	A list and description of all claims either paid or in a pended status which is issued each payment cycle for each Provider.
Shared Health Facility	See definition at end of Glossary.
UPC	Universal Product Code.
Void	A transaction which has the effect of cancelling the payment of a previously paid claim.

ARTICLE 47

SHARED HEALTH FACILITIES

Section 4700. Statement of legislative findings and intent.
4702. Definitions.
4704. Shared health facilities, registration.
4706. Shared health facilities; required notification.
4708. Shared health facilities; prohibited practices; administrative requirements.
4710. Shared health facilities; quality of care requirments.
4712. Shared health facilities; rules and regulations.
4714. Shared health facilities advisory council.
4716. Construction.
4718. Separability.

§ 4700. Statement of legislative findings and intent. The legislature hereby finds that the provision of health care in shared health care facilities has become an important source of health services in this state and that such facilities are important mechanisms for the delivery of health care services which have largely been created by the funding provisions of the state program of medical assistance for needy persons. The legislature also finds and declares that certain practices exist in the medical assistance program which have resulted in abuses requiring the regulation of shared health facilities. The legislature further declares it to be the public policy of the state to regulate shared health facilities and to set necessary standards for review of practices and care rendered in these facilities.

§ 4702. Definitions. For the purposes of this article, the following terms shall have the following meanings: 1. "Program" shall mean the New York state program of medical assistance for needy persons, as provided in title XI of article five of the social services law.

2. "Shared health facility" or "facility" means any arrangement wherein four or more practitioners licensed under the provisions of articles one hundred thirty-one, one hundred thirty-one-a, one hundred thirty-two, one hundred thirty-three, one hundred thirty-seven, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-six or one hundred fifty-nine of the education law, one or more of whom receives payment under the program and whose total aggregate monthly remuneration from such program is in excess of five thousand dollars for any one month during the preceding twelve months, (a) practice their professions at a common physical location; and (b) share (i) common waiting areas, examining rooms, treatment rooms or other space, or (ii) the services of supporting staff, or (iii) equipment; and (c) a person, whether such person is a practitioner or not, is in charge of, controls, manages or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at said common physical location, other than the direct furnishing of professional services by the practitioners to their patients, or a person makes available to the practitioners the services of supporting staff who are not employees of the practitioners. "Shared health facility" does not mean or include practitioners practicing their profession as a partnership provided that members of the supporting staff are employees of such legal entity and if there is an office manager, or person with similar title, he is an employee of the legal entity whose compensation is customary and not excessive for such services and there is no person described in paragraph (c) of this subdivision. "Shared health facility" does not mean or include any entity organized pursuant to the provisions of article twenty-eight of this chapter or operating under a certificate issued pursuant to the provisions of articles thirteen and eighty-one of the mental hygiene law; nor shall it mean or include a facility wherein ambulatory medical services are provided by an organized group of physicians pursuant to an arrangement between such group and a health services corporation operating under article nine-c of the insurance law or a health maintenance organization operating under article forty-four of the public health law, and where the health services corporation or the health maintenance organization is reimbursed on a prepaid capitation basis for the provision of health care services under New York state's medical assistance program.