

**NEW YORK STATE
MEDICAID PROGRAM**

**PHYSICIAN
POLICY GUIDELINES**

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The following policy guidelines apply to participation in the
Medicaid Fee-for-Service Program.

Managed Care Organizations (also referred to as Prepaid Capitation Plans) cover the care of many Medicaid enrollees and may have other qualifications for participation and offer additional services.

If you are interested in participating in Medicaid Managed Care as well as Fee-for-Service, information is available at:

<http://www.health.ny.gov/nysdoh/mancare/mcmain.htm>

Section I - Requirements for Participation in Medicaid

This section outlines the requirements for participation in the New York State (NYS) Medicaid Program.

Who May Provide Care

A person currently licensed and registered by the NYS Department of Education (NYSED), and meeting the qualifications of State Education Law, Article 131, may provide services. License requirements are established by the NYS Department of Education (NYSED), and can be found at:

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

If practicing in outside of New York State, physicians must meet the certification requirements of the appropriate agency of the state in which he/she practices.

Physicians must meet the qualifications of a general practitioner or specialist to participate in the NYS Medicaid Program.

General Practitioner Continuing Education Requirements

A general practitioner may continue to qualify by providing satisfactory evidence of completion of a total of 150 hours of continuing education, over a three-year period, in accordance with standards approved by the State Commissioner of Health. These requirements include the following:

- 🕒 Not less than 50 of the 150 hours required, shall consist of attendance at planned instruction, which shall include one or more of the following:
 - ▶ Courses conducted by a Medical School or School of Osteopathy;
 - ▶ Planned continuing education preceptorships or similar practical training approved on an individual basis by the Medical Society of the State of New York (MSSNY) or the NYS Osteopathic Society;
 - ▶ For no more than 20 hours of credit in any given year, preparation and/or presentation of acceptable scientific exhibits or papers evaluated by the MSSNY or the NYS Osteopathic Society;

- ▶ Continuing education approved for this purpose by the MSSNY or the NYS Osteopathic Society.
- ⌚ The remaining 100 hours of continuing education shall be satisfied by the accumulation of credit, on an hour-for-hour basis, for attendance at specific scientific meetings, such as the following:
 - ▶ Meeting of local, state, or national medical societies including county medical societies, county osteopathic societies, academies of medicine, meetings of AMA, etc.;
 - ▶ Attendance at scientific programs, hospital staff meetings or similar medical meetings;
 - ▶ Teaching at a teaching hospital, medical school, nursing school, or other school offering a curriculum that includes some branch of the health sciences;
 - ▶ As a preceptor for medical students;
 - ▶ Other continuing education activities, in conjunction with the MSSNY or the NYS Osteopathic Society.

Specialists

On the basis of standards approved by the State Commissioner of Health, a specialist is a licensed physician who:

- ⌚ is a Diplomat of the appropriate American Board, or Osteopathic Board; or
- ⌚ has been notified of admissibility to examination by the appropriate American Board, or Osteopathic Board, or presents evidence of completion of an appropriate qualifying residency approved by the American Medical Association (AMA), or American Osteopathic Association; or
- ⌚ holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
- ⌚ in psychiatry, a physician may be recognized as a specialist if he/she satisfies the following additional alternatives:

- ▶ has been Chief or Assistant-Chief Psychiatrist in an approved psychiatric clinic and is recommended for approval by the Director of Psychiatry of the Community Mental Health Board; or
- ▶ graduated from medical school prior to July 1, 1946, and during the last five years has restricted practice essentially to psychiatry, and is certified by the Commissioner of the State Office of Mental Health (OMH) after approval by a committee of the NYS Council of District Branches of the American Psychiatric Association appointed for this purpose by the President of the Council.

Physicians Holding a Limited License or Limited Permit

Physicians holding a limited license may provide services either in a facility setting or in a fee-for-service setting but only in an underserved area. The limitation is on geographical location not on scope of practice. The DOH is responsible for monitoring the compliance with the practice requirement that limited license physicians practice in a medically underserved area.

The licensee is entitled to practice medicine as though fully licensed, without supervision or other restriction.

*Physicians with limited **licenses** are responsible for seeking the approval of the DOH if they plan to move to another underserved area or otherwise modify the practice arrangements approved at the time the limited license was issued.*

*Physicians holding a limited **permit** in NYS are **not** licensed to practice medicine except under the supervision of a licensed and currently registered physician. As such, a physician with a limited permit may not **enroll** in Medicaid and cannot receive any direct fee-for-service **payment**.*

Registered Physician's Assistants

Services rendered by a registered physician's assistant (RPA) must be in accordance with the provisions outlined in Article 131A of the NYS Education Law and Article 37 of the NYS Public Health Law. License requirements are established by the NYSED, and can be found at: <http://www.op.nysed.gov/med.htm>

Physicians and physician's groups must ensure that RPAs they employ are enrolled as *non-billing Medicaid providers*.

RPA's may be employed by physicians or by Article 28 facilities. They may perform medical services, but only under the supervision of a physician; duties must be assigned by the supervising physician, and be appropriate to the education, training, and experience of the RPA.

A physician may supervise no more than two RPA's in his/her private practice and no more than six (6) RPA's employed by a hospital.

Reimbursement

The services of RPA's will be reimbursed as follows:

- ⌚ Payment will be made to the physician who employs the RPA.
- ⌚ Payment will be according to the standard fees that physicians normally receive. This applies whether the physician, the employed RPA, or both individuals provide the service.
- ⌚ The physician for a service may make no duplication or increase in charges, solely because an RPA has provided assistance.
- ⌚ The only exception is "Physician Assistant Services for Assist at Surgery". Please refer to the [Fee Schedule](#) for instructions on the use of Modifier '-AS'.
- ⌚ All claims for Medicaid reimbursement that are submitted by physicians must include an indication of those services or procedures that were rendered by or in conjunction with the RPA and also the name and Medicaid provider identification number of the RPA who rendered the care.
- ⌚ The professional component for all services provided by a physician assistant (PA) in an Article 28 hospital outpatient department, hospital inpatient setting, emergency department, ambulatory surgery setting and diagnostic and treatment center (D&TC) for Medicaid fee-for-service patients is included in the APG or APRDRG payment to the facility. Supervising physicians and physician groups may not bill Medicaid separately for PA services provided in these settings.

Nurse Practitioners

Medicaid policy guidelines for Nurse Practitioners can be found online at:

<http://www.emedny.org/ProviderManuals/NursePractitioner/>

Physician Requirements as a Member of a Group

Physicians may be in individual practices or practice with others in a group. If the services are provided in a group setting, the group must be a definable and legitimate entity which is enrolled in the Medicaid Program as a group provider.

All providers that submit claims to the Medicaid Program for group reimbursement must identify:

- ⌚ The Medicaid provider number of the individual who provided the services; and,
- ⌚ The group Medicaid provider number (where services are provided in a legitimate group setting).

In this case, payment will be made to the group provider number. Use of any other provider number is prohibited.

Requirements of Individuals in a Group

- ⌚ All individual practitioners in the group must be enrolled as Medicaid providers. Pursuant to federal and State regulations, no individual in the group may be a sanctioned provider.
- ⌚ The group must immediately notify the Medicaid Program, in writing, of the following:
 - ▶ Addition or deletion of group members;
 - ▶ Change in ownership of the group;
 - ▶ Change/addition in address or service location
- ⌚ Any individual practitioner leaving a group must also notify the Medicaid Program, in writing, with the effective departure date.

🕒 Provider maintenance forms are available online at:
<http://www.emedny.org/info/ProviderEnrollment/>

🕒 Send written notification to:

eMedNY
P.O. Box 4610
Rensselaer, NY 12144-4610

🕒 Upon leaving the group, a practitioner may no longer use the group provider number. Likewise, a group may not use the provider number of an individual who has left the group.

Where an individual practitioner leaves the group and fails to notify the Department in writing, the individual's liability for group activity will continue. Since all Medicaid providers are individually liable for submitted claims that use their individual provider number, providers are strongly cautioned to guard against the inappropriate use of their Medicaid provider number.

Group Compensation

Members of the group will either be principals (associates), employees, independent contractors or a combination of the above.

- 🕒 The compensation agreement between group members must be in writing, and must be made available to the Department upon request.
- 🕒 Federal and State anti-kickback provisions provide for administrative and criminal penalties for improper compensation arrangements. Improper arrangements usually involve compensation paid on a percentage basis. (Since not all such arrangements are illegal, you may wish to seek the advice of counsel regarding these issues.)

Liability

Any individual practitioner in the group, or their designated agent (including billing agents), may certify a Medicaid claim for payment where the group number is used on the Medicaid claim.

As stated above, an individual's Medicaid provider number may not be used to bill for services performed by other group members. Where a group provider number is used on the Medicaid claim, the individual provider of care *must* be identified.

When a group provider number is used in Medicaid claiming, regardless of who certifies the claim:

- 🕒 All members in the group are liable for overpayments;
- 🕒 All members are subject to administrative sanctions (termination from Medicaid) and could be subject to criminal penalties for such violations as filing a false claim;
- 🕒 The unauthorized use of any individual's Medicaid provider number without their knowledge and consent is prohibited and is subject to administrative sanctions or prosecution; and
- 🕒 Where an individual leaves the group and fails to notify the Department in writing, liability for group submission of claims continues until such time as the Department receives written notification of the departure.

Submission of Claims to the Medicaid Program

When billing for any type of group practice (group of associates, or group employing other physicians or dentists) the information below must be entered into the appropriate field:

- 🕒 The group Medicaid identification (ID) number (assigned by the Department at the time of enrollment as a group); and
- 🕒 The physician, dentist, or other practitioner who actually provided the service must be identified by entering his/her Medicaid ID number.
- 🕒 Where group services are provided at multiple locations, the place of actual service must be entered.

If you are submitting claims as an individual, you are required (with certain exceptions as stated below) to have rendered the service, certify as such, and utilize your individual provider number.

A physician, dentist, or other practitioner enrolled in Medicaid **only as an individual provider** must not use his/her individual provider ID number to bill Medicaid for services actually provided by another physician or dentist except for the following two situations:

- ⌚ when a physician is supervising an RPA or certified social worker (CSW). In this situation, the RPA or the CSW must be identified; or
- ⌚ when a locum tenens agreement is in effect.

If the group is affiliated with a hospital or other Article 28 entity, but is a separate and definable entity (that is, the members of the group are not employees of the hospital), the group **may not** utilize the provider number of the hospital. The entity is required to enroll as a group and utilize the group Medicaid provider number for billing.

Sanctions

Administrative sanctions (exclusions and terminations) and the recovery of overpayments by the Department may result from improper claiming and from the failure to comply with group notification requirements.

Child Abuse or Maltreatment Reporting Requirements

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

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

Reports by mandated reporters are made to the State Central Register by calling the Mandated Reporter Hotline at:

(800) 342-3750.

Record Keeping Requirements

Physicians are required to maintain complete, legible records in English for each Medicaid-eligible patient treated. As required by Medicaid regulations, medical records shall include as a minimum, but shall not be limited to the following:

- ⌚ The full name, address and medical assistance program identification number of each patient examined and/or treated in the office for which a bill is submitted;
- ⌚ The date of each patient visit;
- ⌚ The patient's chief complaint or reason for each visit;
- ⌚ The patient's pertinent medical history as appropriate to each visit, and findings obtained from any physical examination conducted that day;
- ⌚ Any diagnostic impressions made for each visit;
- ⌚ A recording of any progress of a patient, including patient's response to treatment;

- 🕒 A notation of all medication dispensed, administered or prescribed, with the precise dosage and drug regimen for each medication dispensed or prescribed;
- 🕒 A description of any X-rays, laboratory tests, electrocardiograms or other diagnostic tests ordered or performed, and a notation of the results thereof;
- 🕒 A notation as to any referral for consultation to another provider or practitioner, a statement as to the reason for, and the results of, such consultations;
- 🕒 A statement as to whether or not the patient is expected to return for further treatment, the treatment planned, and the time frames for return appointments;
- 🕒 A chart entry giving the medical necessity for any ancillary diagnostic procedure;
- 🕒 All other books, records and other documents necessary to fully disclose the extent of the care, services and supplies provided.

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

Section II - Physician Services

Under the Medicaid Program, physician services may be provided as medically indicated to eligible patients.

Lead Screening Tests

Federal Medicaid standards and NYS law require that all children be screened with a blood lead test at 1 and 2 years of age. The federal Medicaid rules require that children between 3 and 6 years of age be tested if they have not been previously tested.

In addition to universal blood lead testing of all 1 and 2 year old children, primary health care providers should assess each child, who is at least 6 months of age but under 6 years of age, for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines.

Each child found to be at risk for high dose lead exposure should be screened or referred for blood lead screening and follow-up testing is required for children identified with elevated blood lead levels. Lead poisoning prevention resources can be found online at: <http://www.health.ny.gov/environmental/lead/index.htm>.

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Health care providers other than the child's primary care provider are required to inquire if the child has been appropriately assessed and screened for lead poisoning in accordance with DOH regulations.

If the child has not been previously screened, the provider shall screen or refer the child for lead screening.

Prenatal care providers are required to assess pregnant women for risk of high-dose exposure to lead and to screen or refer for lead screening as indicated.

Only laboratories certified for toxicology-blood lead under Article 5 Title V of the Public Health Law can perform blood lead tests. Venous blood specimens should be used whenever practicable but fingerstick specimens are acceptable if collection procedures minimize the risk of environmental lead contamination.

Screening Mammography

The order for screening mammography needs to be in accordance with medical necessity. This may include establishing baseline data and referring for periodic testing based on age and family history of the patient.

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

These regulations pertain to any person or facility that operates mammography equipment, reads mammograms, or processes mammography images. To become certified, the facility and/or individuals must first be accredited by a federally approved non-profit organization or state agency.

HIV Enhanced Fees for Physicians Program

The HIV Enhanced Fees for Physicians (HIV-EFP) Program recognizes the need to encourage primary care for persons with HIV disease by increasing fees for primary care and specialty physicians who provide HIV counseling, testing and follow-up care. The new fees are comparable to those paid by commercial insurers.

To claim for services under the HIV-EFP, the provider must be both enrolled in the Medicaid Program and meet the HIV-EFP eligibility and practice criteria. These criteria

include board certification, hospital admitting privileges and twenty-four hour coverage of the physician's practice, among others.

HIV-EFP enrollment forms are available online at:

<http://www.emedny.org/info/ProviderEnrollment/>

Medicaid Payment for Rapid HIV Testing

The Medicaid Program supports the use of rapid, technologically simple devices in order to increase access to early HIV diagnosis and treatment and prevention services.

Physicians enrolled in the *HIV Enhanced Fee for Physicians (HIV/EFP) Program* will be eligible for Medicaid reimbursement for HIV antibody screening tests that he or she performs, personally or through practice employees, as an adjunct to the treatment of their patients. Physicians performing HIV screens should use procedure code 86701, HIV-1 antibody, up to a maximum of one test per six month period per patient.

Physicians that would like to enroll in the HIV/EFP Program should contact:

**New York State Department of Health
AIDS Institute
Attn: HIV Ambulatory Care Administrator
Room 459 Corning Tower
Albany, New York 12237
Phone: (518) 473-3786 Fax:
(518) 473-8905.**

In order for a physician to be reimbursed for HIV tests, his or her physician office laboratory must:

- ⌚ be registered with Clinical Laboratory Improvement Amendments (CLIA), the federal laboratory oversight program, and
- ⌚ hold certification appropriate for CLIA categorization of the test device being used and must be registered with Medicaid as a Physician Office Laboratory (POL).

Physicians may apply for a CLIA certificate by contacting the Physician Office Laboratory Evaluation Program and requesting an application form via email to:

CLIA@health.ny.gov.

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The application is also posted on the Centers for Medicare and Medicaid Services' website: <http://www.cms.hhs.gov/clia/>.

A completed application must be submitted to the address of the local State agency for the state in which you will conduct testing. Physicians conducting testing in New York State should send their completed CMS-116 form to:

**New York State Department of Health Wadsworth Center
Physician Office Laboratory Evaluation Program
P.O. Box 509 Albany, NY 12201-0509**

Physicians that already hold a CLIA certificate, but are not enrolled with Medicaid as a POL, must mail a completed *Physician Office Laboratory – CLIA Information* form available online at: <http://www.emedny.org/info/ProviderEnrollment/>

Methadone Maintenance Treatment Program

A Methadone Maintenance Treatment Program (MMTP) means those diagnostic, preventive or rehabilitative services concerned with the therapeutic administration of methadone by or under the supervision of a qualified physician.

In accordance with the rules and regulations of the DOH, only physicians, groups of physicians or medical facilities that have been authorized by State and Federal authorities, may conduct MMTPs.

Authorization to conduct a MMTP by a physician, groups of physicians or by a medical facility requires certification under Article 28 or 33 of the Public Health Law by the DOH and approval from the Food and Drug Administration of the United States Department of Health and Human Services. The NYS Office of Alcoholism and Substance Abuse Services may require additional accreditation.

Scope of Services

MMTPs are to administer a medically approved dosage of methadone in a therapeutic setting designed to enhance the functioning of enrollees. Any prescribed drug regimen must be limited to the treatment by the Program's operating certificate and must conform to other required procedures.

Laboratory Services Performed by Physicians

The Medicaid Program will deny claims for laboratory tests performed in physician office laboratories (POL) if the POL has an expired Clinical Laboratory Improvement Amendment (CLIA) certification or if the POL bills for tests which are not approved in the POL's current CLIA certificate. If a physician performs laboratory tests for his or her own patients and bills Medicaid for these services, the physician must complete the *CLIA Information* form located at: <http://www.emedny.org/info/ProviderEnrollment/>

and include a copy of:

- 🕒 the physician's most recent CLIA Certificate of Waiver/Registration, or Certificate of Compliance or Accreditation; or
- 🕒 a current letter from the Center for Medicare and Medicaid Services (CMS), or the DOH (Wadsworth).

Forms and CLIA Certificates of Waiver/Registration, Compliance and/or Accreditation for multiple sites operated by the same provider or group of providers may be submitted in one mailing. *However, information for each eligible physician in a group must be recorded on a separate form.*

Medicaid will pay for only those tests covered by the physician's CLIA certificate and will deny payment on claims for lab tests performed in the physician's office if the physician failed to provide Medicaid with the necessary CLIA information.

CLIA Certificate of Compliance/Accreditation

Payment is available for all laboratory services procedure codes found below.

CLIA Certificate – Physician Performed Microscopy Procedures (PPMP) Payment is available for the following laboratory procedure codes ONLY:
81002, 81015, 81025, 85013, 85018, 85651, 87082

CLIA Certificate of Waiver

Payment is available for the following procedure codes ONLY:
81000, 81002, 81025, 85013, 85018, 85651, 87082

Limitations on Reimbursement for Laboratory Procedures

A physician or other practitioner cannot be reimbursed for clinical laboratory services, which have been provided by a qualified clinical laboratory or by a hospital.

Reimbursement for Venipuncture for Specimen Collection

Costs of venipuncture for specimen collection for laboratory testing are included as part of the payment for the office visit.

Section III - Basis of Payment for Services Provided

Payment for physician services will not exceed the maximum fee established by the DOH and promulgated by the NYS Director of the Budget. The fee schedule for physician services is available online at:

<http://www.emedny.org/ProviderManuals/Physician/>

Physicians who are enrolled in the Preferred Physicians and Children Program, the Medicaid Obstetrical and Maternal Services Program or the HIV Enhanced Fees for Physicians Program will be paid in accordance with the enhanced fees for those programs.

Payment

Physicians are responsible for the policies relayed in the [Information for All Providers – General Policy](#) and [General Billing](#) manuals in addition to the information contained in this manual.

Reimbursement will **not** be made for appointments for medical care which are not kept.

Medicaid reimbursement is available to a physician for medical services provided in:

- ⌚ an office,
- ⌚ a home,
- ⌚ a hospital,
- ⌚ a residential health care facility, or
- ⌚ elsewhere when the patient has chosen the physician as a personal physician and when the physician has accepted that patient as a private patient on the same basis as self-paying patients or patients covered by other forms of thirdparty payments.

Payment will be made to additional physicians called in by the personal physician for consultation or for specialized services. Treatment records should clearly substantiate the medical necessity for such a consultation.

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

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

Medicaid payment for services may be made directly to:

- ⌚ The individual physician; or,
- ⌚ The group which employs the physician; or,
- ⌚ The group of which he/she is a member.

In accordance with State laws, a physician may employ another physician, or physicians of like licensure may organize as either a partnership or as a professional corporation to provide health care services.

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

It is a violation of State laws for a non-physician entrepreneur to employ physicians for the provision of health care services.

Medicaid payment is based upon the direct provision of a personal and identifiable service to the enrollee. Payment is not appropriate for appointments for medical care, which are not kept, or for services rendered by a physician to a patient over the telephone. The completion of medical forms may be necessary in certain situations, but such completion does not justify a separate bill to Medicaid.

Additional billing to the enrollee for a covered cost is an unacceptable practice.

Physician Services Provided in Article 28 Facilities

Medicaid reimbursement is available to a physician for medical services provided in Article 28 hospital inpatient and outpatient settings for Medicaid fee-for-service patients. This policy became effective on February 1, 2010.

Previously, if a physician was salaried by a hospital facility and his/her salary was included in the facility cost report, the clinic or inpatient payment to the hospital was considered payment in full for the service. The physician was prohibited from submitting a fee-for-service claim to Medicaid.

The physician's professional services are carved-out of APG or APR-DRG payments and may be billed in addition to the APG or APR-DRG facility payment for services provided in the following settings:

- Hospital-Based Ambulatory Surgery Settings
- Emergency Departments
- Hospital Outpatient Clinics
- Free-standing Ambulatory Surgery Centers
- Inpatient Settings (including exempt, per-diem inpatient rates)

When hospital emergency department, ambulatory surgery (hospital-based and freestanding) and hospital outpatient clinic rate codes for APGs or inpatient rate codes for APR-DRGs are billed, the physician may also submit a separate claim to Medicaid for their professional services. This includes physicians who are on staff and salaried by the hospital.

In order to bill, physicians providing services in these settings must be enrolled in New York State Medicaid. The HIPAA 837P billing format must be used. Physicians should bill Medicaid using the fee schedule published in the Physician Provider Manual.

The above noted physician carve-out policy for hospital-based services does not apply to diagnostic and treatment centers (D&TCs). Physicians providing services in D&TCs may not bill Medicaid. The practitioner professional component for all D&TCs is included in the APG payment to the clinic.

Pay and Seek

In the case of certain ambulatory pregnancy-related services, and primary care provided to children, Medicaid pursues a "pay and seek" method of reimbursement. This means

that you should bill Medicaid for certain diagnosis codes **without** first pursuing any available third party insurance.

In order to trigger “pay and seek,” physicians should leave the Other Insurance Paid field blank on the claim. If approved, Medicaid will then pay the claim and pursue any available third party coverage directly.

Locum Tenens Arrangements

Federal law requires that payment for services be made to the provider of service. An exception to this requirement may be made when one physician arranges for another physician to provide services to his/her patients under a locum tenens arrangement.

The law allows such locum tenens arrangements:

- On an informal, reciprocal basis for periods not to exceed 14 days; or,
- For periods of up to 90 days with a more formal agreement.

Record of either arrangement must be maintained **in writing** to substantiate locum tenens payment.

Physicians who are enrolled in the PPAC or the MOMS Program **must** make locum tenens arrangements with physicians who are also enrolled in the PPAC or MOMS program in order to receive the enhanced fees associated with these programs. *If locum tenens arrangements are made with physicians who are not enrolled in the respective programs, the locum tenens payment will be made at the regular Medicaid fee.*

Locum tenens arrangements should not be made with any physicians who have been disqualified by the NYS Medicaid Program.

The service authorization, which is requested through MEVS, must be in the name of the billing physician, not in the name of the service provider, in a locum tenens arrangement.

Critical Care

The Medicaid Program allows for physicians to bill two distinct procedure codes when critical care is rendered to an eligible Medicaid enrollee:

99291 *Critical care, evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first hour;*

99292 *Each additional 30 minutes (listed separately, in addition to code 99291 for primary service).*

When a physician bills Medicaid either or both of the procedure codes above, the services listed below are **included**. Therefore, when billing the above procedure codes, the following services (with applicable procedure codes following in parentheses) should **not** be billed in addition to the Critical Care procedure codes:

- The interpretation of cardiac output measurements (93561, 93562);
- Chest X-rays (71010, 71015, 71020);
- Pulse oximetry (94760, 94761, 94762);
- Blood gases, and information data stored in computers (99090);
- Gastric intubation (43752, 91105);
- Temporary transcutaneous pacing (92953);
- Ventilatory management (94656, 94657, 94660, 94662); and
- Vascular access procedures (36000, 36410, 36415, 36540, 36600).

Services performed that are not listed above should be separately reported.

Additionally, when critical care is provided by a physician during transport, the critical care codes 99291 and 99292 should be reported for the physician's attendance.

For additional procedure codes, please see the [Procedure Codes and Fee Schedule](http://www.emedny.org/ProviderManuals/Physician/) at: <http://www.emedny.org/ProviderManuals/Physician/>

Payment for Immunizations

Children under nineteen (19) years of age with Medicaid coverage are among children for whom the Federal government now supplies certain routine childhood vaccines at no

cost to providers who are registered with the *Vaccines for Children (VFC) Program*. For Medicaid eligibles under nineteen (19) years of age, Medicaid will not reimburse providers for the cost of vaccine available through VFC without charge.

Medicaid enrolled physicians, nurse practitioners and referred ambulatory providers must be registered with the VFC program in order to receive reimbursement for administering VFC-provided vaccine to Medicaid eligibles less than nineteen (19) years of age. The appropriate Evaluation and Management Service may also be billed. To obtain VFC information and/or registration material, call:

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

For more information about other cohorts of Medicaid enrollees, please call

(518) 473-2160.

Hemodialysis Services

Payment to physicians for the provision of hemodialysis services most commonly comes from the facility where the services are performed.

If the physician's costs for hemodialysis services are excluded from the facility's rate, the appropriate codes to use for claiming end stage renal disease related services should be used. The codes are specific to age groupings.

Radiological Services

Only a physician who is a specialist in radiology shall ordinarily provide radiological services. In order to bill Medicaid for both the technical and professional components of any fee listed in the Radiology Section of the [Fee Schedule](#), radiologists must perform the professional component of the radiology service and must own or lease the equipment. Also, the radiologist must supervise and control the radiology technicians who perform the radiology procedures. If the equipment is owned by a hospital or clinic, the radiologist may bill for the professional component provided the radiologist receives no compensation from the facility for patient care.

Radiologists who provide radiology services in mobile settings must perform the professional component of the radiology service and must own or directly lease the equipment and must employ the radiology technicians who perform the radiology procedures.

If a radiologist reviews a film sent to him/her by a physician who took the film on equipment owned by that physician, the cost of that professional review is borne by the physician. The radiologist must not bill Medicaid in this situation.

A fully qualified physician specialist other than a radiologist may only provide radiological services related and limited to his/her special field. Any other qualified physician may provide radiological services as necessary, but limited to routine diagnostic chest X-rays and/or diagnostic X-rays for acute injuries.

The examination of the gastrointestinal tract by performance of gastrointestinal series and barium enema examinations require the use of fluoroscopic methods and of films; one without the other is insufficient. All gallbladder series require erect and/or decubitus views necessary to determine the presence or absence of pathology.

Private practicing radiologists may provide computerized tomography (CT) scan services. Magnetic Resonance Imaging (MRI) services are available only from designated facilities who have received appropriate certificate of need approval from the Department of Health. Physicians will not be reimbursed for the professional component or the global fee for MRI services.

Reimbursement for Magnetic Resonance Imaging

Medicaid coverage of magnetic resonance imaging (MRI) services includes reimbursement to physicians for either the complete procedure or the professional component. For information regarding the correct billing for the professional or technical/administrative components, see the Radiology Section of the [Billing Guidelines](#).

When billing for only the professional component, it is imperative that the physician's claim be billed with Modifier 26. Absence of the appropriate modifier on the physician's claim will result in claim denials for the provider billing for the technical/administrative component.

Ophthalmologic Services

To qualify for reimbursement as an ophthalmologist, a physician must meet Medicaid specialty requirements in the field of ophthalmology. More information is available in the [Vision Care Policy](#) manual, online at: <http://www.emedny.org/ProviderManuals/VisionCare/>

Psychiatric Services

To qualify for reimbursement as a psychiatrist, a physician must meet Medicaid specialty requirements in the field of psychiatry.

Psychiatric care may be reimbursed by Medicaid when provided by a qualified psychiatrist in his/her office, in the patient's home, in a clinic, a general or chronic disease hospital or approved medical institution or facility operated in compliance with applicable provisions of law; or, for persons either under 21 or aged 65 and over, in a public hospital caring exclusively or primarily for patients with mental disease. A person in such a facility who was receiving this care prior to reaching age 21 may continue until his/her 22nd birthday. As part of sound medical practice, a private practicing psychiatrist who provides care to a enrollee should share information regarding the patient's status with his/her source of primary medical care, following appropriate consent procedures.

See the policy guidelines in the [Child \(Foster\) Care Agency Provider Manual](#) or a discussion on Medicaid reimbursable psychiatric services rendered to foster care youth within child (foster) care agencies.

Qualified Social Worker

For purposes of this section, the term "qualified social worker" refers to a qualified and currently licensed social worker under [State Education Law](#).

For Medicaid payment purposes, a psychiatrist in private practice may employ up to four social workers. These social workers may provide psychiatric care only under the continuing direct supervision of the employing psychiatrist as part of a course of treatment. Such supervision must include regular, direct communication and consultation between the social worker and the supervising psychiatrist, but not construed as requiring the actual physical presence of the supervising psychiatrist at the time the services are being performed by the social worker. The number of social workers providing services supervised by one qualified supervising psychiatrist may not exceed four.

The psychiatrist must assign duties and responsibilities performed by the social worker. They must be within the scope of practice of the psychiatrist, and be appropriate to the education, training and experience of the social worker.

The provision of services by a social worker must be preceded by the completion of a diagnostic evaluation of the patient by the psychiatrist.

The psychiatrist is responsible for developing an overall treatment plan which integrates the social worker's study of the patient, and describes the services to be provided by the social worker. The services provided by the social worker may include the following:

- The taking of a social history (if taken during an office visit), which includes all relevant information useful to the patient's treatment;
- Counseling the patient, if counseling is done during an office visit;
- Conducting group therapy sessions, if conducted during an office visit;
- Making relevant visits to the patient's home and family to assure the efficacy of the supervising psychiatrist's treatment plan;
- Submitting regular reports to the supervising psychiatrist, which keeps him/her informed of any changes in the patient's circumstances, or condition which may influence the outcome of the patient's treatment. The reports must be retained by the supervising psychiatrist and incorporated into the patient's medical record as previously stated in "Medicaid Records to be Maintained".

Services provided by social workers may be reimbursed only to the employing psychiatrist and only when provided in the psychiatrist's office or in the patient's home. A patient's home is not to be considered a facility such as a skilled nursing facility or hospital.

See the policy guidelines in the [Child \(Foster\) Care Agency Provider Manual](#) for information regarding reimbursable mental health services rendered to foster care youth within child (foster) care agencies, including mental health services provided by licensed social workers following the requirements in New York State Education Department licensure and scope of practice statutes.

Payment for services performed by a social worker for a Medicaid enrollee who is not a Qualified Medicare Beneficiary (QMB) may be made only to the psychiatrist for services which the social worker is qualified to perform.

Social workers providing services to Medicaid enrollees who are not QMBs may **not** bill independently for their services.

Although Medicaid does not reimburse for services provided by social workers to Medicaid enrollees who are not QMBs, claims for payment submitted by a psychiatrist for services performed by a social worker in his/her employ must include the name and

license number of the social worker providing such services. Reimbursement is limited to the maximum reimbursable fees for such service.

Note: Medicaid will make payment for Medicare deductibles and coinsurance, as appropriate, to certain clinical social workers (CSWs) for CSW services to individuals known as QMBs. Only those CSWs enrolled in Medicaid for "clinical social worker for QMB services only" will be reimbursed directly.

Only services to individuals eligible as QMBs will be covered for deductibles and coinsurance, as appropriate, for CSW services directly reimbursed to Medicaid enrolled CSWs. The local department of social services determines QMB eligibility.

Record Keeping Requirements

Psychiatrists must maintain medical records containing information sufficient to justify the diagnosis and warrant the treatment of each Medicaid patient served. As part of this documentation, each medical record shall include:

- Identifying information about the person treated;
- Current diagnosis as contained in an approved nomenclature manual such as ICD10-CM;
- A description of the patient's problems, strengths, conditions, disabilities and needs;
- A statement of the goals and objectives of treatment to address the patient's problems, disabilities and needs, including an estimate of the duration of the patient's need for treatment, a description of the proposed treatment and prognosis;
- Progress notes providing a chronological description of the patient's progress in relation to the goals and objectives of the established plan of treatment; and
- A summary of the patient's condition and disposition when treatment is completed or terminated.

Citing of the above requirements is not meant to limit the medical record to only this information. A psychiatrist is expected to document other supporting facts concerning the patient's past or present care or condition, including any reports submitted by a supervised psychiatric social worker.

Patient medical records must be retained for six years in accordance with established Medicaid regulations.

Supervising/Teaching Physicians

Supervising/teaching physicians who are not being directly reimbursed by a facility for patient care services may bill Medicaid while supervising a resident, provided that personal and identifiable services are provided by the teaching physician to the patient in connection with the supervisory services.

- The supervising/teaching physician must provide appropriate documentation in the patient medical record, including the extent of their participation in the history, examination, and complexity of the medical decision-making used to determine the level of service, as required by the Physicians' Current Procedural Terminology.
- If the documentation would be repeating information already obtained and documented by the resident, the teaching physician need only summarize comments that relate to the resident's entry.
- Under current documentation policy, teaching supervisors need not repeat documentation already provided by a resident:
- When services are provided to a Medicaid enrollee by a resident physician in a hospital outpatient department or freestanding clinic setting, notes entered in the medical record by the resident need not be repeated by the supervising/teaching physician. However, the supervising/teaching physician must personally document at least the following:
 - That they performed the service or were physically present during the key or critical portions of the service when they were performed by the resident; and
 - Their participation in the management of the patient.

Note: The documentation should also reference the resident's notes.

Regardless of whether physician costs are included in or excluded from a facility's rate structure, a facility may bill Medicaid for a clinic visit performed by a resident only when there is appropriate supervision and documentation in the record.

Adequate documentation, along with the supervising/teaching physician's countersignature, indicates involvement of the teaching/supervising physician and

makes the provided service billable to Medicaid. These documentation requirements pertain to both salaried physicians and physicians who bill Medicaid fee-for-service.

Primary Care Exception

With respect to evaluation/management visits in primary care settings where encounters entail medical decision making of low or moderate complexity, teaching physicians may bill for services rendered to a patient, even though the services were furnished without their presence, provided the Medicare Primary Care Exception conditions are met.

These conditions include the requirement that teaching physicians:

1. Supervise no more than four residents at a time;
2. Be immediately available and have no other responsibilities at the time the patient is being seen by the resident;
3. Assume management responsibility for the patients and ensure that the services rendered are appropriate;
4. Review with the resident, during or immediately following each visit, the key elements of the services provided;
5. Document the extent of their participation in the review and direction of services.

Surgical, High Risk, or Other Complex Procedures

Teaching physicians are responsible for preoperative, operative, and post-operative care. They should be present during all critical and key portions of these types of procedures, and should be immediately available to return to the procedure throughout the entire process.

To bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

Clarification on Particular Situations

Endoscopic Surgery

Viewing an endoscopic procedure via a monitor in another room would not qualify for payment.

Diagnostic Radiology and Other Diagnostic Tests

If a resident prepares and signs the interpretation, teaching physicians must indicate that they personally reviewed the image and the resident's interpretation and either agree with it or edit the findings. Countersignatures would not qualify for payment.

Hematology/Oncology

Bone marrow aspirates and biopsies may be billed only when teaching physicians are present with the resident for the full duration of the procedure, and assure that adequate material has been obtained.

Psychiatry

Teaching physicians must concurrently observe the service by one-way mirror or video equipment, audio only equipment would not suffice.

Maternity Services

Teaching physicians must be present in the room for the delivery, and their presence must be appropriately documented in the record.

Anesthesiology

Teaching anesthesiologists may be paid when they are involved in a procedure with a resident, but must be present during induction and emergence. They may not bill for anesthesia time during concurrent supervision of more than one resident.

Other Complex and Invasive Procedures

Teaching physicians may bill only when they are present with the resident for the full duration of complex procedures such as interventional radiological and cardiology supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography

Reimbursement for Drugs Administered in a Physician's Office

The Medicaid Program reimburses for drugs furnished by physicians to their patients on the basis of the acquisition cost to the practitioner of the drug dose administered to the patient. *For all drugs furnished in this fashion, it is expected that **the physician will maintain auditable records** of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice.*

To facilitate electronic claim submission and timely payment to physicians, the Medicaid Program consults national pricing references to establish a maximum reimbursable amount (MRA) on its procedure code reference file. Claims submitted for most physician-supplied drugs will be paid automatically up to the MRA price. However, drugs listed in the Physician Fee Schedule with a notation of BR (By Report) under the Maximum Fee column must be submitted on a paper HCFA 1500 Claim Form, with a copy of the itemized invoice as documentation. Regardless of whether a particular drug is designated as BR (By Report) in the Medicaid Physician Fee Schedule, **Medicaid does not intend to pay more than the acquisition cost of the drug dosage**, as established by invoice, to the practitioner. Even if an invoice must be submitted to Medicaid for payment, the physician is expected to limit the charged amount to the actual invoice cost of the drug dosage administered.

Practitioner Administered Drug Policies and Billing Guidance

The Medicaid program has issued policies and billing guidance for certain drugs/drug classes. These drugs are eligible for reimbursement when the clinical criteria outlined at [New York State Medicaid Fee-for-Service Practitioner Administered Drug Policies and Billing Guidance \(ny.gov\)](#) and in Medicaid Update articles are met.

Drug claims must include the documentation of clinical criteria and must include the following:

- Manufacturer's invoice showing the acquisition cost of the biologic, including all discounts, rebates or incentives;
- Documentation of the medication administration; and
- Documentation of the criteria listed under the NYS Medicaid Coverage Policy section

Clinical criteria worksheets are available for drugs/drug classes subject to clinical criteria. These worksheets outline the clinical and claim documentation requirements, provide a step-by-step outline of the requirements, and are designed to ensure complete claim documentation submission. A completed worksheet, and the manufacturer invoice showing the drug acquisition cost, including all discounts, rebates and incentives can be submitted with the HCFA 1500 Claim Form. Clinical criteria worksheets can be found online at: New York State Medicaid Fee-for-Service Practitioner Administered Drug Policies and Billing Guidance (ny.gov)

Regardless of whether a particular drug is designated as BR (By Report) in the Medicaid [Physician Fee Schedule](#), **Medicaid does not intend to pay more than the acquisition cost of the drug dosage**, as established by invoice, to the practitioner. Even if an invoice must be submitted to Medicaid for payment, the physician is expected to limit the charged amount to the actual invoice cost of the drug dosage administered.

Billing When Two Surgeons Are Involved

When two surgeons (usually of different skills) work together as primary surgeons performing distinct part(s) of a single reportable procedure, add modifier –62 to the procedure code number.

One surgeon should file one claim line representing the procedure performed by the two surgeons.

The billing surgeon will apportion the total payment in relation to the responsibility and work done.

Section IV - Ordering Services and Supplies

The purpose of ordered services is to make available to the private practitioner those services needed to complement the provision of ambulatory care in his/her office. It is not meant to replace those services which are expected to be provided by the private practitioner nor is it meant to be used in those instances when it would be appropriate to admit a patient to a hospital, to refer a patient to a specialist for treatment, including surgery or to refer a patient to a specialized clinic for treatment. Services must be provided in accordance with the ordering practitioner's treatment plan.

A licensed physician or other person so authorized by law must order services in writing. In emergencies only, the request of the ordering practitioner may be verbal; however, the verbal request must be followed by a written order.

Reports of Services

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

Payment for Services

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

Laboratory Tests

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

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

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

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

Orders for laboratory tests must indicate the diagnosis, symptomatology, suspected condition or reason for the encounter, either by use of the **appropriate** ICD-10-CM code or a narrative description. Use of the ICD-10-CM code V72.6 does not satisfy this requirement.

It is the responsibility of the ordering practitioner to ascertain that the laboratory to which he/she is referring specimens or patients has not been excluded from participation in the Program and holds appropriate New York State and/or New York City Laboratory permits.

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

abnormal result is inappropriate if a repeat of the single test is sufficient to address the clinical question.

Drugs

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

Long-term maintenance drugs are drugs ordered or prescribed with one or more refills in quantities of a 30 day supply or greater, drugs ordered or prescribed without refills in quantities of a 60 day supply or greater, drugs ordered or prescribed for family purposes or, prescriptions written and dispensed on the official New York State prescription form for up to a three month supply when written in conformity with the Controlled Substance Act (title IV or article 33 of the Public Health Law).

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

A fiscal order or prescription for drugs and supplies may not be refilled unless the prescriber has indicated on the prescription/order form the number of refills. Medicaid permits refills for supplies, prescription and non-prescription drugs as ordered up to a maximum of five refills.

The pharmacist shall substitute a generic drug, whenever available, if an FDA approved therapeutically and pharmaceutically equivalent product is listed in the publication "Approved Drug Products with Therapeutic Equivalence Evaluations" (The Orange Book), unless the prescriber writes "daw" (dispense as written) on the prescription form. However, for certain brand name products to be eligible for Medicaid reimbursement at the brand name (EAC) price, prescriber 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.**

Official New York State Prescription Forms

Public Health Law requires that all prescriptions written in New York State be issued on an official New York State prescription form. Register and order these forms at:

<http://www.health.ny.gov/professionals/narcotic/ordering.htm>.

Information is available online at:

<http://www.health.ny.gov/professionals/narcotic/>.

Medicaid Drug Programs

Information regarding Medicaid drug programs, including the Mandatory Generic Program, Preferred Drug Program and Drug Utilization Review Programs; is available online at:

http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

Ordered Ambulatory Services

A hospital or diagnostic and treatment center may perform an ordered ambulatory service only when the treatment, test or procedure has been ordered in writing and is the result of a referral made by a licensed physician, nurse practitioner, dentist, podiatrist, physician's assistant, or mid-wife.

The order must be signed and dated by the ordering provider. In emergencies only, the request of the ordering practitioner may be verbal; however, a written order must later be obtained by the hospital or diagnostic and treatment center. In all cases, the written order must be received by the facility within a period of two working days from the time of the verbal request.

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

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

The attending/ordering practitioner will be reimbursed on a fee-for-service basis for those professional services rendered in the provider's office. The facility will be reimbursed on a fee-for-service basis for those services rendered within the facility, in conjunction with the guidelines stated in the [Clinic Provider Manual](#).

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

Procedures When Ordering/Recommending Out-Of-State Medical Care

Prior Approval is required in most instances, when referring a Medicaid enrollee to an out-of-state provider for medical care and services.

For details on requesting out-of-state medical care, please see the [Inpatient Policy Guidelines Manual](#).

Laboratory Tests Ordered from an Independent Clinical Laboratory

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

Physician Manual Policy Guidelines

The practitioner must individually order laboratory tests ordered from an independent laboratory. Certain tests may be ordered in a test grouping or panel format. The following tests may be ordered as a **single test** on the order form:

- CBC
- Urinalysis

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

- | | | | |
|-----------------------|------------------|-----------------------|--------------|
| • SMA-6* | • Chloride | • Protein | • SGOT |
| • Glucose | • Carbon Dioxide | • Albumin | • Bilirubin |
| • BUN (Urea Nitrogen) | • SMA-12Z* | • Uric Acid | • Creatinine |
| • Sodium | • Calcium | • Cholesterol | |
| • Potassium | • Phosphorus | • Alkaline Phosphates | |

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

The following groupings of automated chemistry tests may be ordered as a panel:

Panel	Must Include
Basic Metabolic	<ul style="list-style-type: none"> • Calcium, • Carbon dioxide, • Chloride, • Creatinine, • Glucose, • Potassium, • Sodium, • Urea nitrogen
Electrolyte	<ul style="list-style-type: none"> • Carbon dioxide, • Chloride, • Potassium, • Sodium

Comprehensive Metabolic	<ul style="list-style-type: none"> Albumin, • Bilirubin total, • Calcium, • Carbon dioxide, • Chloride, • Creatinine, • Glucose, Phosphatase alkaline, 	<ul style="list-style-type: none"> • • Potassium, • Protein total, • Sodium, • Transferase, alanine amino, Transferase, • aspartate amino, • • a nitrogen. Ure
Lipid	<ul style="list-style-type: none"> • Cholesterol, • serum, • total, • Lipoprotein, 	<ul style="list-style-type: none"> • direct measurement, high- • density cholesterol, • triglycerides
Renal Function	<ul style="list-style-type: none"> • Albumin, • Calcium, • Carbon dioxide, • Chloride, • Creatinine, • Glucose, 	<ul style="list-style-type: none"> • • Phosphorus, • inorganic, Potassium, • Sodium, • Urea nitrogen •
Hepatic Function	<ul style="list-style-type: none"> • • Albumin Bilirubin, • total, Bilirubin, • direct, • Phosphatase, alkaline, • 	<ul style="list-style-type: none"> • • Protein, total, • Transferase, alanine amino, Transferase, • aspartate amino. •

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

Ordering Medical Transportation

Please see information in the [Information for All Providers – General Policy Manual](#), online at:

<http://www.emedny.org/ProviderManuals/Physician/>

Section V - Definitions

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

Critical Care

Extraordinary care by the attending physician in person attendance in the care of a medical emergency, both directing and personally administering specific corrective measures after initial examination had determined the nature of the ailment.

Diagnostic Ultrasound Services

Diagnostic ultrasound services are services that include ultrasonic scanning and measurement procedures such as echoencephalography, echocardiography and peripheral vascular system studies.

Family Planning

Family planning services are those health services which enable individuals, including minors who may be sexually active, to plan their families in accordance with their wishes, including the number of children and age differential, and to prevent or reduce the incidence of unwanted pregnancies. Such services include, but are not limited to:

- ⌚ professional medical counseling,
- ⌚ sterilization,
- ⌚ insertion of Norplant,
- ⌚ prescription drugs,
- ⌚ non-prescription drugs and
- ⌚ medical supplies prescribed by a qualified physician, RPA or nurse practitioner.

Family planning services do not include hysterectomy procedures or sterilization of individuals less than 21 years of age; nor the treatment of infertility.

General Practitioners

A General Practitioner is a physician who:

- ⌚ is a member of the active or attending staff at a hospital holding a valid operating certificate from the NYS Department of Health (DOH); or
- ⌚ is a member in good standing of the American Academy of General Practice or the American College of General Practitioners in Osteopathic Medicine and Surgery; or
- ⌚ has given satisfactory evidence of completion of a total of 150 hours of continuing education over a three-year period based on standards approved by the State Commissioner of Health.

Hospital Based Ambulatory Surgery

Adopted regulations define a hospital-based ambulatory surgery service as a

"...hospital-based service involving surgery on patients under anesthesia in an operating room and necessitating a hospital stay of less than 24 hours in duration."

Institutionalized Individual

An institutionalized individual is an individual who is either involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Medical Consultation Services

Medical consultation services are services that include those occasions when the primary care physician perceives the need for his/her patient to consult a specialist.

Medically Necessary Services

Medically necessary services are those necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or

infirmity, interfere with his/her capacity for normal activity or threaten some significant handicap and which are furnished to an eligible person in accordance with this title and the regulations of the Department.

Medicine Services

Medicine services are services that include specific diagnostic and therapeutic procedures such as electrocardiograms, electroencephalograms, and pulmonary function testing;

Mentally Competent Individual

A "mentally incompetent individual" refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Narcotic Addict

A narcotic addict is a person who, at the time of examination, is dependent upon opium, morphine, heroin, or any derivative or synthetic drug of that group.

Only narcotic addicts are eligible to participate in a Methadone Maintenance Treatment Program.

Ordered Ambulatory Patient

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

Ordered Ambulatory Service

An ordered ambulatory service is a specific service performed by a hospital or diagnostic and treatment center possessing an operating certificate issued by the Department of Health. Such service is provided on an ambulatory basis, upon the written order of a qualified physician, nurse practitioner, physician's assistant, dentist or podiatrist to test, diagnose or treat an enrollee or a specimen taken from a enrollee. Such services may include a singular occasion of service or a series of tests or treatments provided by or under the direction of a physician.

Ordered ambulatory services include:

- Laboratory services, including pathology;
- Diagnostic radiology services, including CT scans;
- Diagnostic nuclear medicine scanning procedures;

Ordered Service

An ordered service is a specific, medically necessary service or item performed by or provided by a qualified provider upon the written order of a qualified practitioner. Examples of ordered services include laboratory services, pharmacy services, durable medical equipment, private duty nursing, medical services, radiology services, cardiac fluoroscopy, echocardiography, non-invasive vascular diagnostic studies and consultations. Services of podiatrists in private practice are available only for persons under age 21 with a written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

Psychological Evaluation Services

Psychological evaluation services are services performed by a clinical psychologist, including testing.

Therapeutic Services

Therapeutic services are services that include radiotherapy, chemotherapy and rehabilitation therapy services.