

**NEW YORK STATE
MEDICAID PROGRAM**

**POLICY GUIDELINES MANUAL FOR
ARTICLE 28 CERTIFIED CLINICS**

DRAFT

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Section I – General Information for Clinic Providers

Basis of Payment

For Medicaid patients, the basis of payment for most clinic services provided in hospital outpatient departments and diagnostic and treatment centers under Article 28 of the Public Health Law is the threshold visit. New York State Department of Health (DOH) regulation at 10 NYCRR 86-4.9 states:

“A threshold visit occurs each time a patient crosses the threshold of a facility to receive medical care without regard to the number of services provided during that visit.”

Only **one** threshold visit per patient per day is allowed for reimbursement purposes, except for transfusion services to hemophiliacs, in which case each transfusion visit constitutes an allowable threshold visit. The visit is **all-inclusive** as it includes all of the services medically necessary and rendered on that date.

This policy does **not** apply to those services for which rates of payment have been established for each procedure, such as dialysis and freestanding ambulatory surgery.

When a Medicaid patient receives treatment(s) during a threshold clinic visit that cannot be completed due to administrative or scheduling problems, the Article 28 facility may **not** bill additional clinic visits for the completion of the service.

For example, the completion of clinical laboratory test, blood draws or X-rays that are scheduled subsequent to the initial clinic visit do not qualify for reimbursement unless the patient is also seen for purposes of discussing the findings and for definitive treatment planning.

It is inappropriate for a clinic to call a client back for a service in order to generate an additional clinic visit for a service that should have been provided at the time of the first visit (and included in that payment).

For example, if a patient needs both physical and occupational therapy on the same day, a clinic cannot provide one session on the first day and call the patient back for a second visit on a subsequent day to generate another clinic bill.

Completion of a Clinic Service

When a Medicaid-eligible patient receives treatment during a threshold clinic visit which cannot be completed due to administrative or scheduling problems, the Article 28 facility may not bill additional clinic visits for completion of the service.

For example, the completion of clinical laboratory tests or X-rays, the results of which are interpreted on a day subsequent to the patient's initial threshold visit,

do not qualify for reimbursement unless the patient is seen for purposes of discussing the findings and for definitive treatment planning.

Payment will only be made for one emergency room visit per day per Medicaid-eligible patient unless the facility can document that an additional Medicaid-eligible patient visit is made for a different illness.

When a Medicaid-eligible patient is treated in a facility's emergency room and clinic on the same day, payment can only be claimed for both visits if:

- the emergency room and the outpatient non-emergency room visit have discrete rates, and
- the facility can document that the visits were made for different illnesses.

When a Medicaid-eligible patient is admitted as an inpatient on the same day as a clinic or emergency room visit, payment can be claimed only for the inpatient cost per discharge.

Payment to the hospital under diagnosis related groups (DRGs) or per diems is payment in full.

No emergency room or clinic services may be billed to Medicaid during the Medicaid-eligible patient's inpatient stay, i.e., billing additionally for an MRI while a patient is hospitalized.

Prior Approval and Authorization

No prior approval or authorization is required for services covered by a facility's Medicaid rate or for [ordered ambulatory services](#).

All out-of-state services beyond the common medical marketing area, except emergencies, require prior approval.

Out-of-State Care

Out-of-state facilities must meet the certification requirements of the appropriate agency of the state in which the facility is located.

Documentation of Services Provided

Adequate documentation of services provided must be recorded in the Medicaid-eligible patient's chart.

If, during an audit, the individual's chart supporting payment for services cannot be produced or does not substantiate payment, the full amount paid for visits by that Medicaid-eligible patient will be recouped by the State.

When services to a Medicaid-eligible patient have been provided by a physician who is not currently licensed, but who is legally practicing pursuant to pertinent provision of [10 NYCRR 405.4](#), the supervising physician's license number or Medicaid identification number may be entered on the claim. Title 10 is searchable online at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>.

The services provided to a Medicaid-eligible client must be under the direction of the supervising physician who has agreed to allow his/her license number to be used in this manner.

Patient records must reflect who actually provided the necessary service to the Medicaid-eligible patient.

Proper Billing Requirements for Clinics

When billing the Medicaid Program for services provided by a hospital-based or freestanding clinic, providers are required to include the appropriate procedure code(s) that identifies the service(s) rendered to a Medicaid enrollee.

The procedure code entered on the claim **must** reflect the actual service rendered to the patient and must be consistent with the scope of practice, certification and/or profession of the rendering provider.

For example, an Evaluation and Management code may only be reported on a clinic claim when the service is rendered by a qualified licensed practitioner, such as a physician, nurse practitioner, licensed midwife or registered physician's assistant.

Additionally, clinics are required to include an appropriate diagnosis code which reflects the condition being treated at the clinic visit. The principal diagnosis (the primary reason for the clinic visit) should be reflected in the diagnosis code that is reported on the claim.

Record-Keeping Requirements

In addition to meeting the requirements outlined in this Manual, providers must meet the record-keeping requirements for their particular type of facility outlined in the regulations of the DOH.

For Medicaid purposes, records must be maintained for **six years** from the date of payment.

Anti-Kickback Advisory

It is an unacceptable practice for clinical laboratories and diagnostic and treatment centers, specifically rate-based facilities such as dialysis facilities, to provide or receive laboratory services at no charge.

Federal anti-kickback statute (Stark Law) makes it a criminal offense to knowingly and willingly offer, pay, solicit or receive any compensation to induce or reward referrals of services reimbursable by the State Medicaid Program. Medicaid providers that engage in practices prohibited under federal anti-kickback rules and/or New York State laboratory business practice law and implementing regulations are at substantial risk for exclusion from the Medicaid Program.

New York State rules expressly prohibit a laboratory's supplying:

"employees, agents or other fiduciaries...to a referring health services purveyor to perform functions and duties in the facility of the health services purveyor."

New York State regulations provide an exception when the purveyor is a hospital, and the laboratory and the hospital have entered into a contract for laboratory management services, including provision of technical services and employees for the performance of functions directly related to laboratory operations at the hospital.

Section II – Hospital Outpatient Departments, Diagnostic and Treatment Centers, Emergency Rooms

Scope of Services

Hospital outpatient departments and diagnostic and treatment centers may provide those necessary medical, surgical, and rehabilitative services and items and authorized by their operating certificates.

An emergency room may provide those necessary diagnostic and treatment procedures dealing with urgent and emergency conditions including:

- medical and surgical services;
- suction;
- inhalation;
- resuscitation;
- drugs;
- supplies and other necessary procedures when life is endangered.

A physician must see all patients who arrive for treatment in the emergency room.

In compliance with certification procedures, providers are responsible for maintaining required policies and practices relating to staffing patterns, facility availability, and service functions.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in DOH regulations.

Medicaid covers abortions which have been determined to be medically-necessary by the attending physician.

Social Services Law Section 365-a.2 specifies the types of medically-necessary care, including medically-necessary abortions, which may be provided under the Medicaid Program.

Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

Ordered Ambulatory Services

The purpose of ordered ambulatory services is to make available to the private practitioner or clinic (other than the ordered ambulatory provider) those services needed to complement the provision of ambulatory care.

Ordered ambulatory services are not meant to replace those services which are expected to be provided by the private practitioner or clinic, nor are they 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.

Who May Provide Services

Ordered ambulatory services may be provided by a hospital or a diagnostic and treatment center possessing an operating certificate for that service issued by the DOH and meeting the requirements for participation in Medicare.

Orders for Services

Ordered ambulatory services must be ordered in writing by the Medicaid-eligible patient's attending physician, nurse practitioner, physician's assistant, dentist or podiatrist who is providing direct patient care services.

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.

In accordance with the aforecited policy, the attending/ordering practitioner will be reimbursed on a fee-for-service basis for those professional services rendered in the practitioner's office, as referenced within the appropriate Provider Manual/Fee Schedule available online at:

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

The clinic where the attending/ordering practitioner works (which is not the ordered ambulatory service facility) will be reimbursed its established rate.

The ordered ambulatory provider will be reimbursed on a fee-for-service basis for those ordered ambulatory services rendered within the facility, in accordance with the appropriate Ordered Ambulatory Fee Schedule, available online at:

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

Physical therapy, occupational therapy and speech-language pathology services may **only** be ordered by:

- Physicians,
- Nurse practitioners, or
- Physician's assistants.

Scope of Services

Ordered ambulatory services include:

- Laboratory services, including pathology;
- Diagnostic radiology services, including CT scans;
- Diagnostic nuclear medicine scanning procedures;
- Medicine services, including specific diagnostic and therapeutic procedures such as electrocardiograms, electroencephalograms and pulmonary function testing;
- Diagnostic ultrasound services, including ultrasonic scanning and measurement procedures such as echoencephalography, echocardiography and peripheral vascular system studies;
- Therapeutic services, including radiotherapy, chemotherapy and rehabilitation therapy services.

If the facility providing these therapeutic services incorporates such costs into its clinic rate calculation, then the Medicaid-eligible patient must be registered as a clinic patient and the clinic rate must be billed.

Under these circumstances, the services cannot be provided on an ordered ambulatory basis. The clinic is assuming primary responsibility for the care of the patient; therefore, the clinic is not obligated to send reports on each occasion of diagnostic or treatment service to the patient's primary care physician.

If, however, the therapeutic services are not included in a clinic rate calculation, they may be billed by the facility on a fee-for-service basis. Such billings must be

submitted in accordance with reimbursement guidelines set forth in the [Ordered Ambulatory Services Provider Manual](#).

- Medical consultation services, including those occasions when the primary care physician perceives the need for his/her patient to consult a specialist who is employed by a hospital or diagnostic and treatment center.

If, in the process of or subsequent to providing such medical consultation, it is determined that continuing care of the patient by the facility is warranted, the patient should become either a clinic patient or an inpatient of the facility and the facility's rate must be billed.

For reporting purposes, the facility must include these costs and statistics in the appropriate cost centers of its annual cost report. The facility cannot bill fee-for-service for ancillary services ordered by an on-site consulting specialist.

As with medical consultation, psychological evaluation services performed by clinical psychologists on an ordered ambulatory basis are considered single instance services. They do not include ongoing treatment sessions and may only be billed once per Medicaid-eligible patient when ordered by the primary care practitioner for completion of a particular treatment plan.

Reports of Services

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

Payment for Services

Payments for ordered ambulatory services will be made only to the facility actually furnishing the care.

Claims for ordered ambulatory services will be paid only on a fee-for-service basis and not at an all-inclusive inpatient, emergency or clinic rate. Payment will be no higher than the applicable [Fee Schedule](#) amount.

Ordered Ambulatory Products

In addition to ordered ambulatory services, facilities and diagnostic and treatment centers may provide "ordered ambulatory goods", which have been ordered by a qualified physician, nurse practitioner, physician's assistant, dentist or podiatrist in accordance with appropriate scope of practice.

Such goods include:

- Prosthetic and orthotic appliances;

- Hearing aids;
- Durable medical equipment; and
- Blood products.

The ordering practitioner may be employed by the facility or he/she may be in private practice. The Medicaid-eligible patient receiving the goods may be, but does not necessarily need to be, a clinic patient.

Payment will be made for ordered ambulatory goods only on a fee-for-service basis and will be limited to the lower of the actual acquisition cost of the goods or the New York State-approved fee. There will be no dispensing fee or mark-up allowed.

Immunizations

For information regarding Medicaid reimbursement of immunizations provided in Article 28 Hospital-Based and Freestanding Clinic settings, please refer to the following chart.

Patient Status	Age	Visit/Services	Billing Guidance
Registered Clinic Patient	Any Age	Patient is receiving primary care services.	This is a qualifying threshold visit and is reimbursed at the clinic rate.
Registered Clinic Patient	Any Age	Patient is receiving primary care services and an immunization.	This is a qualifying threshold visit and is reimbursed at the clinic rate.
Registered Clinic Patient	Under 19 Years of Age	Patient visits for immunization only. Vaccine is provided to the clinic by the Vaccines For Children Program.	This is not a qualifying threshold visit. However, the clinic may bill the Healthcare Common Procedure Coding System (HCPCS) procedure code that represents the immunization provided, appended with the modifier 'SL' and will be paid as an Ordered Ambulatory service. <i>From a regulatory perspective, this is not really an Ordered Ambulatory service. We are using the Ordered Ambulatory billing construct to allow Vaccines for Children Program reimbursement.</i>

Policy Guidelines Manual for Article 28 Certified Clinics

Patient Status	Age	Visit/Services	Billing Guidance
Registered Clinic Patient	19 Years of Age or Older	<p>Patient visits for immunization only.</p> <p>The vaccine is not provided by the Vaccines for Children Program.</p>	<p>Immunizations should routinely be given as part of a qualifying threshold visit.</p> <p>Seasonal immunizations (e.g., influenza vaccine) may not be available at the time of a patient visit. It should be provided when available without billing for an additional threshold visit.</p> <p>A separate threshold visit may be billed only when immunization is medically contraindicated at the time of the encounter with the health provider, since it is expected that the patient's health status will be reassessed prior to immunization.</p> <p>When a patient must return to complete a series of vaccinations, a separate threshold visit for each encounter may be billed when provided by a recognized practitioner.</p>
In a Products of Ambulatory Care Clinic	Any Age, Any Patient	<p>Patient is receiving an immunization only.</p> <p>The service is provided by a physician, physician assistant, nurse practitioner, or licensed midwife.</p>	<p>This is grouped and paid as a Products of Ambulatory Care reimbursement.</p>
Ordered Ambulatory Patient	Under 19 Years of Age	<p>Patient visits for immunization only.</p> <p>Vaccine was provided by the Vaccines for Children Program.</p>	<p>This is not a qualifying threshold visit.</p> <p>However, the clinic may bill the HCPCS procedure code, appended with the modifier 'SL' and will be paid as an Ordered Ambulatory service.</p>

Patient Status	Age	Visit/Services	Billing Guidance
Ordered Ambulatory Patient	19 Years of Age or Older	Patient visits for immunization only. Vaccine is not provided by the Vaccines for Children Program.	This is not a qualifying threshold visit. However, the clinic may bill the HCPCS procedure code that represents the immunization provided at their actual acquisition cost for the vaccine plus administration.

Contact Information

Vaccines for Children Program
(800) 543-7469

DOH Immunization Program
(518) 474-4578

Psychiatric Social Work Services in Federally Qualified Health Centers

Medicaid payment is available for psychiatric social work services provided in Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and Rural Health Clinics (RHCs). This policy also applies to programs that are solely certified as Article 28 clinics and have been designated by the Federal Centers for Medicare and Medicaid Services (CMS) to meet the criteria for these categories of health centers.

Medicaid will pay for individual clinical social services (psychotherapy) provided by certified social workers in Article 28 Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and Rural Health Centers.

Psychotherapy services provided by certified social workers are billable under the following circumstances:

- Services must be provided by a certified social worker with psychotherapy privileges on their State Education Department certification, or a certified social worker who is working in a clinic under qualifying supervision in pursuit of such certification.
- Payment will only be made for services that occur in sites that have been certified as FQHCs, FQHC Look-Alikes, or Rural Health Centers by CMS.
- Payment will be permitted only for *psychotherapy* services.
- The certified social worker must only be identified on the claim by entering his/her New York State License Number with License Type 45.

Clinical social services are defined as individual psychotherapy services provided in a Federally Qualified or Rural Health Center by a licensed clinical social worker who has received or is working in a clinic under qualifying supervision in pursuit of a psychotherapy privileges certification by the New York State Education Department.

The following psychotherapy services provided by certified social workers are **not** billable to the Medicaid Program:

- Services rendered at part-time clinics;
- Group psychotherapy; and
- Case management, medical social services, or related services.

Psychiatric Social Work Services: Clarifying Questions and Answers

The following questions and answers apply only to clinics certified solely by DOH (unless otherwise indicated):

Licensure

What is a licensed master social worker?

Social workers are certified by the State Education Department. Certified social workers have a master's degree in social work and meet certain certification requirements.

Is a clinic eligible for payment if the psychotherapy service is provided by a certified social worker?

Effective September 1, 2004, the licensure requirements and titles for social workers changed. On or after September 1, 2004, payment is available only for services rendered by a licensed **clinical** social worker (LCSW) or a Licensed Master Social Worker (LMSW) who is working in a clinic setting under qualifying supervision in pursuit of licensed clinical social work status by SED.

A social worker who holds a CSW prior to September 1, 2004 will have qualified to have been grandfathered as a Licensed Master Social Worker beginning September 1, 2004.

What is qualifying supervision for a CSW working towards psychotherapy certification?

Specifics can be found in Part 74.5 of the State Education Department regulations, and is available at:

<http://www.op.nysed.gov/part74.htm>.

What is considered “qualifying supervision” for a LMSW working toward clinical social work licensure?

Supervision must conform to SED regulations.

Record-keeping

What are the standards and record-keeping requirements that must be met for Medicaid billing of social work services in an Article 28 FQHC clinic?

First, clinic services certified by DOH must be provided by or under the direction of a physician. As such, we would expect a written physician’s order for the psychotherapy service.

A characteristic of psychotherapy provided in a DOH (Article 28) certified clinic is that the therapy is expected to be short term and of limited duration, and provided incidental to general health care. Long term psychotherapy, as a treatment for a severe emotional disorder, would normally be provided in a clinic certified by the Office of Mental Health under Article 31 of the Mental Hygiene Law.

In addition to the items that must be maintained in the enrollee case record, as specified in this Manual, such case record must also include the following information at a minimum:

- A signed and dated treatment plan that includes, but is not limited to, the enrollee’s diagnosis, the enrollee’s treatment goals and the number of sessions ordered by the physician/psychiatrist. The physician involved in the treatment must sign treatment plans and, in doing so, is ordering the service and certifying the medical necessity of those services.
- Dated and signed progress notes for each visit/contact identifying the session content and duration, as well as changes in goals, objectives, and services. The clinical person who provided the service must write such notes.
- Periodic assessment of enrollee’s progress toward goal.

Billing

When can clinics receive reimbursement for clinical social work services?

Article 28 clinics that are designated as FQHC, FQHC Look-alikes, or RHC may bill Medicaid for psychotherapy services provided by qualified social workers for services rendered on or after November 1, 2003.

The ability to bill for psychotherapy by qualified social workers does not confer the right to operate a program of mental health services. Such a program would be subject to licensure by the Office of Mental Health.

What are the requirements for a clinic to bill for these services?

In order to be eligible for reimbursement, a clinic must meet ALL of the following:

- Be an Article 28 clinic (enrolled in Medicaid as either category of service **0160**-diagnostic & treatment center or **0287**-hospital based outpatient department);
- Have designation by the CMS as a FQHC, FQHC Look-alike, or RHC;
- Be approved by the Office of Health Systems Management (OHSM) to provide psychotherapy as noted on the clinic's operating certificate.

What procedure codes should a clinic bill?

Only individual psychotherapy is a covered service. Therefore, **only** procedure codes for individual psychotherapy should be billed using the appropriate codes.

Case management or medical social services are not billable as a clinic visit.

What payment does a clinic receive for providing these services?

This service is considered a [threshold visit](#). Therefore, clinics receive their facility's all-inclusive clinic rate.

Must psychotherapy services be ordered by a physician?

Yes, a physician must order psychotherapy services.

Can an Article 28, designated by CMS as an FQHC, bill for family counseling services?

Medicaid payment for social work services provided in a FQHC, FQHC Look-alike, or RHC is not allowed for group services.

Family counseling may be billed for one member of the family only.

If the primary entity or parent corporation Article 28 facility has been designated by CMS as a FQHC, FQHC Look-alike or RHC, may all sites affiliated with that parent corporation bill the FQHC rate for social work services?

No, it cannot be assumed that all sites of a FQHC are themselves eligible for FQHC status. FQHC status must be held by any site billing for social work services.

Can a dually certified (e.g. Article 28/Article 31 certification) FQHC clinic, bill for psychotherapy services provided by a social worker in a group setting?

Medicaid reimbursement for psychotherapy services provided in Article 28 FQHC clinics is only available for individual, one-on-one services when rate codes 1610 or 2870 are billed. If group psychotherapy is needed, the patient should be referred to a clinic licensed by OMH, OASAS or OMRDD.

Alternatively, clinics (including FQHCs) that are also certified as clinics by OMH (Article 31), OASAS (Article 32) and OMRDD (Article 16) may provide and bill for group psychotherapy consistent with the rules of these agencies.

Any clinic providing significant mental health services to persons with mental illness needs to be certified by the OMH and should apply for such licensure.

In all cases, if group therapy is being rendered in an OMH, OMRDD, or OASAS clinic, the service must be billed using the group therapy rate codes authorized by these agencies.

It should be noted that while OMRDD clinics do provide the services of psychologists, psychiatrists and social workers, services in any particular clinic depend on the availability of these types of staff, and the current caseloads of these clinic staff.

Ambulatory Surgery Services

Ambulatory surgery services are services provided in hospitals and free-standing facilities to patients under anesthesia in an operating room and necessitating a stay of less than 24 hours in duration.

Ambulatory surgery patients utilize the operating room, recovery room, anesthesia services and other related ancillary services in the course of their treatment. Outpatient surgical procedures typically performed in a physician's office of ambulatory treatment room setting are not considered ambulatory surgery.

Payment for ambulatory surgery is based on a case mix adjusted ambulatory payment system called Products of Ambulatory Surgery (PAS). Facilities must use a set of PAS grouper access codes for billing ambulatory surgery procedures. eMedNY automatically converts the PAS grouper access rate code to the specific rate code that corresponds to the appropriate PAS group.

Only one principal procedure PAS rate code can be billed per operative session. An additional procedure is only billable if the procedure is classified in a different PAS group than the principal procedure. Multiple additional procedures are only billable if each procedure is classified in a PAS group, which is different than the initial procedure and any other additional procedures. Pre-admission testing is not included in the PAS rates.

Annually, the DOH sends eMedNY rate codes to enrolled providers.

If patient complications require that a procedure needs to be performed in an ambulatory surgery setting, then the facility must maintain prior approval. For more information on billing, please refer to the Billing Guidelines Manual at:

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

Utilization Threshold Program

In order to render services for physician, clinic, laboratory, pharmacy and dental clinic care, it is necessary for providers to obtain an authorization from the Electronic Medicaid Eligibility Verification System (EMEVS). This authorization to render services will be granted unless a Medicaid-eligible patient has reached his/her utilization threshold limits.

In order to obtain additional services, an ordering provider must submit a "Threshold Override Application." To obtain Utilization Threshold Override Application Forms, please contact Computer Sciences Corporation at:

(800) 343-9000.

It certain special circumstances, such as emergencies, providers *do not need authorization from EMEVS*.

Arrangements have also been made to permit a provider to request a service on a *retroactive* basis. In requesting retroactive service authorization, a provider risks their request being denied if the Medicaid-eligible patient has reached his/her limit in the interim.

After a provider receives an authorization, a claim may be submitted to Computer Sciences Corporation for processing. For claims guidelines, please refer to the **Information for All Providers – General Billing Manual** online at:

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

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

Laboratories that need to determine whether tests are needed on an emergency or urgent basis shall consult with the ordering provider, unless the order form indicates that an urgent or emergency situation exists. Those limited laboratory services that can be rendered by a physician or podiatrist in private practice to his/her own patients do not count toward the laboratory utilization threshold.

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

- “managed care services” furnished by or through a managed care program, such as a
 - health maintenance organization,
 - preferred provider plan,
 - physician case management program or
 - other medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program;
- services otherwise subject to prior approval or prior authorization;
- reproductive health and family planning services, including:
 - diagnosis, treatment, drugs, supplies, and related counseling furnished or prescribed by or under the supervision of a physician for the purposes of contraception, sterilization, or the promotion of fertility;
 - Medically necessary induced abortions;
 - Screening for:
 - ▶ anemia,
 - ▶ cervical cancer,
 - ▶ glycosuria,
 - ▶ proteinuria,
 - ▶ sexually transmitted diseases,
 - ▶ hypertension,
 - ▶ breast disease,
 - ▶ pregnancy and
 - ▶ pelvic abnormalities;
- Child/Teen Health Program services;
- methadone maintenance treatment services;

- services provided by private practitioners, on a fee-for-service basis, to inpatients in general hospitals and residential health care facilities;
- hemodialysis services;
- school health project services;
- obstetrical services provided by a physician, midwife, nurse practitioner, hospital outpatient department, or a free-standing diagnostic and treatment center;
- primary care services provided by a pediatrician or pediatric clinic; and
- Tuberculosis Directly Observed Therapy (TB/DOT).

Section III – Family Planning Services

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,
- prescription drugs,
- non-prescription drugs and
- medical supplies prescribed by a qualified physician, registered physician's assistant or nurse practitioner.

Billable Family Planning Services

- All Federal Food and Drug Administration approved birth control methods, devices, and pharmaceuticals;
- Emergency contraceptive services and follow-up;
- Male and female sterilization; and
- Counseling, preventive screening and family planning options before pregnancy.

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

- Pregnancy testing and counseling;
- Screening for sexually transmitted diseases (STDs), cervical cancer, and urinary or female-related infections;
- Counseling services related to pregnancy and informed consent, and STD/HIV risk counseling;
- Comprehensive health history and physical examination, including breast exam and referrals to primary care providers. Mammograms are not included;

- Screening and related laboratory tests for medical conditions that affect the choice of birth control, e.g., a history of diabetes, high blood pressure, smoking, blood clots, etc.; and
- HIV counseling and testing.

Abortions and follow-up care are not related to family planning.

Medicaid does **not** cover the treatment of infertility.

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

Patient Eligibility

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

Family planning services, including the dispensing of both prescription and non-prescription contraceptives but excluding sterilization, may be given to minors who wish them without parental consent. Medicaid-eligible minors seeking family planning services may not have a Medicaid ID Card in their possession.

To verify eligibility, the physician or his/her staff should obtain birth date, sex, social security number, or as much of this information as possible, before contacting the Department at:

(518) 472-1550.

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

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

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

Medicaid Verification System Information

The Family Planning Benefit Program (FPBP) is a Medicaid Program that allows enrollees eligible for this coverage to access family planning services only. All enrolled

Medicaid providers who provide family planning services to enrollees with this coverage can be reimbursed for designated family planning services.

The EMEVS will return the following responses when verifying a FPBP eligible enrollee:

- Tranz 330: ELIGIBLE ONLY FAMILY PLAN SRVC;
- OMNI 3750 and ePACES: Limitations and Service type code - 82 (Family Planning);
- Alternate access methods (PC, CPU, Batch): F (Limitations) and Service type code – 82 (Family Planning);
- On-line NCPDP Pharmacy transactions will be rejected for Table 7 Denial Response Code 719 (MA Only Covers Family Planning), unless the submitted Drug is a Family Planning Drug. When a Family Planning Drug is submitted, the transaction will be accepted if all other edits are passed and Response Code 018 is returned.

Patient Rights

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

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

Standards for Providers

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

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

Requirements for Payment

Whenever family planning is provided (either through the FPBP or regular Medicaid), to insure Medicaid payment, the family planning field on the claim form **must** be completed to indicate a family planning service has been provided. This applies to all providers billing for family planning services, e.g. physicians, laboratories, clinics, and nurse practitioners.

If this field is not accurately completed, the service being claimed is not reimbursable. If the service provided is not related to family planning, it cannot be billed under this Program.

Family planning diagnosis codes in the V25 series **must** be used when required on the claim form.

Family planning providers who order laboratory tests related to family planning must indicate on the laboratory requisition form or the written order for the laboratory test that the **test is** related to family planning.

Sterilizations

Medical family planning services include sterilizations. Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

Medicaid reimbursement is available for sterilization only if the following requirements are met:

Sterilization Requirements

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

Informed Consent

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

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

- Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified below under "Waiver of the 30-Day Waiting Period."

Waiting Period

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

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

Waiver of the 30-Day Waiting Period

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

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

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

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

Minimum Age

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

Mental Competence

The patient must be a [mentally competent individual](#).

Institutionalized Individual

The patient to be sterilized must not be an [institutionalized individual](#).

Restrictions on Circumstances in Which Consent is Obtained

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

- in labor or childbirth;

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

Foreign Languages

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

Handicapped Persons

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

Presence of Witness

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

Sterilization Consent Form

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

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed *DSS-3134* in their files.

New York City

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

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

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

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

Hysterectomies

Midwives may need to refer patients for a hysterectomy. Federal regulations prohibit Medicaid reimbursement for hysterectomies which are performed solely for the purpose of rendering the patient incapable of reproducing; or, if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

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

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

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

1. The woman was sterile prior to the hysterectomy;
2. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible. For Medicaid payment to be made in these two cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency. For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;
3. The woman was not a Medicaid enrollee at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application. For these cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above in "1" or "2" was met.

The DSS-3113 documents the receipt of hysterectomy information by the patient or the surgeon's certification of reasons for waiver of that acknowledgement. It also contains

the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

All surgeons, hospitals, clinics and anesthesiologists must submit a copy of the fully completed *DSS-3113* when billing for a hysterectomy. Hospitals and Article 28 clinics submitting claims electronically, must maintain a copy of the completed *DSS-3113* in their files.

Obtaining Sterilization and Hysterectomy Consent Forms

Physicians, nurse practitioners and licensed midwives may request sterilization and hysterectomy consent forms by submitting a written request to:

Forms and Print Management
P.O. Box 1990
Albany, New York 12201.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the DOH.

Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

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

Medicaid also relies on the language from the federal Supreme Court decision *Doe V. Bolton* to further refine the definition for medically necessary abortions. This decision held that the determination that an abortion is medically necessary "*is a professional judgment that may be exercised in the light of all factors - physical, emotional, psychological, familial and the woman's age - relevant to the well-being of the patient. All these factors may relate to health.*"

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

Prenatal Care Assistance Program

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

PCAP offers:

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

In depth information about the PCAP can be found online at:

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

Section IV – Part-Time Clinics

Failure to comply with Department regulations can result in termination from the Medicaid Program, liability for overpayments and criminal prosecution.

County or City Part-Time Clinics

This applies to part-time clinic sites, except for those operated by the State DOH (other than those part-time clinics which are operated as an extension of Article 28 hospitals operated by the DOH) or by the health department of a city or county as such terms are defined in section 614 of the Public Health Law. Such cities and counties shall submit to the DOH information which lists:

- the location(s),
- hours of operation and
- services offered at each part-time clinic operated by or under the authority of the city or county health department.

This information shall be submitted by **January 30 of each year** as an update to the Municipal Public Health Services Plan (MPHSP) submitted by the city or county pursuant to section 602 of the Public Health Law, and shall provide such information for each part-time clinic operated by or under the authority of the city or county health department in the previous calendar year.

A part-time clinic shall:

- Provide services which shall be limited to low-risk (as determined by prevailing standards of care and services) procedures and examinations which do not normally require backup and support from the primary delivery site of the operator or other medical facility.

Such services may include:

- health screening (such as blood pressure screening),
 - preventive health care and other public health initiatives,
 - procedures and examinations (such as Well Child care, the provision of immunizations and screening for chronic or communicable conditions which are treatable or preventable by early detection or which are of public health significance).
- Be located at a site that has adequate and appropriate space and resources to provide the intended services safely and effectively and is located in proximity to

the primary delivery site to ensure that supervision and quality assurance are not compromised; and

➤ Not be located at:

- a private residence or apartment,
- an intermediate care facility,
- **congregate** living arrangements (not including an individualized residential alternative, a shelter for adults or other group shelter operated by governmental or other organizations to provide temporary housing accommodations in a safe environment to at-risk populations),
- an area within an **adult** home, a residence for adults or enriched housing program as defined in section 2 of the Social Services Law unless the part-time clinic is an outpatient mental health program approved by the Office of Mental Health, or
- the private office of a health care practitioner or group of practitioners licensed by the State Education Department, except if the private office space is leased for a defined period of time and on a regular basis for the provision of services as consistent with this policy.

Department Approval and/or Notification

An operator of part-time clinics may initiate patient care services at a specific site only upon written approval from the Department in accordance with the Department's prior limited review process.

To request such approval, the operator shall submit to the Department, for each such site, information and documentation in a format acceptable to the Department and in sufficient detail to enable the Commissioner to make a decision, including the following:

- the location, type and nature of the building, days and hours of operation, expected duration of operation (specified limited period of time, for example, seasonally), staffing patterns and objectives of the part-time clinic;
- the leasing or other arrangement for gaining access to the site's real property, (including a copy of the agreement which grants the applicant the right to use and occupy the space for the part-time clinic site);
- the plans and strategies for meeting the operational standards set forth in this section and an explanation of how the operator will provide adequate supervision and ensure quality of care;
- a listing of all part-time clinic sites already operated by the applicant;

- a description of the services to be provided and the populations to be served; and
- procedures or strategies for advising patients on making arrangement for follow-up care.

After initiating patient care services, an operator of part-time clinics may relocate a part-time clinic or change a category of service only upon written approval from the Department in accordance with the Department's prior limited review process. The operator shall give written notification to the Department at least 45 days prior to the relocation or change in services of a part-time clinic site.

To request approval, the operator shall submit to the Department, for the site of relocation or change in services, information concerning:

- the location, type and nature of the building, days and hours of operation, and expected duration of operation (specified limited period of time, for example, seasonally);
- the leasing or other arrangement for gaining access to the site's real property (including a copy of the agreement which grants the applicant the right to use and occupy the space for the part-time clinic site); and
- a description of the services to be provided and the populations to be served.

After initiating patient care services, the operator shall give written notification, including a closure plan acceptable to the Department, to the appropriate regional office of the Department at least 15 days prior to the discontinuance of a part-time clinic site other than a scheduled discontinuance.

No part-time clinic site shall discontinue operation without first obtaining written approval from the Department.

Unacceptable Practices

Listed below are common violations of State law and regulations by part-time clinic providers:

- Operation of sites in excess of the maximum 60 hours per month;
- Operation of sites not approved by the Department;
- Failure to obtain appropriate licensing;
- Failure to adequately supervise and properly credential staff;

- Operation of sites in prohibited settings such as adult homes;
- Providing services outside the scope of the clinic's operating certificate;
- Failure to prepare and maintain contemporaneous records to support claims for Medicaid payment; and,
- Provision of questionable medical services, which were either not medically necessary or inappropriately billed.

Section V – Dental Clinics

The following information, as well as in-depth Medicaid policy, can be found online in the Dental Provider Manual at:

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

General Policy

- Dental clinics reimbursed on a rate basis (i.e., hospital outpatient departments, diagnostic and treatment centers, and dental schools) are required to follow the policies stated in the [Dental Provider Manual](#).
- The provision of dental care and services are limited in those procedures presented in the [Dental Fee Schedule](#), and are to be provided within the standards and criteria listed in the procedure code descriptions.
- Dental care provided under the Medicaid Program includes only *essential services* (rather than “comprehensive” services).
- When billing:
 - Certifying that the services were provided;
 - Entering the Medicaid ID number of the practitioner who actually provided the service in the “Provider Identification Number” field; and
 - Where services are provided at multiple locations, identifying the place of **actual service** on the claim form.
- Patient medical histories should be updated periodically (annually at a minimum) and be maintained as part of the patient’s dental records. The treating practitioner should refer to the patient history to avoid unnecessary repetition of services.
- Non-emergency initial visits should include a cleaning, X-rays (if required), and a dental exam with a definitive treatment plan. Generally, this should be accomplished in one visit. However, in rare instances, a second visit may be needed for completion of these services. A notation in the record to indicate the necessity for a second visit should be made.
- Quadrant dentistry should be practiced, wherever practicable, and the treatment plan followed in normal sequence.
 - Procedures normally requiring multiple visits (i.e., full dentures, partial dentures, root canals, etc.) should be completed in a number of visits that would be considered consistent with the dental community at large. If additional visits are required, a notation in the patient record to indicate the

necessity for each additional visit should be made.

- Dental X-rays should be clear and allow for diagnostic assessment. They are performed based on need, age, prior dental history and clinical findings.
- Facilities should use the Department's list of providers who may not bill or order services when checking and verifying the credentials of the dental professionals that make up their staff.

This list is currently available on the Department's website at:

http://www.health.state.ny.us/health_care/medicaid/fraud/dqprvpg.htm.

Services Not Within the Scope of the Medicaid Program

- Dental implants;
- Aesthetic veneers, such as porcelain fused to metal crowns (for other than anterior teeth and maxillary first bicuspids);
- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Molar root canal therapy for patients 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis;
- Crown lengthening;
- Replacement of dentures prior to required time periods (currently 4 years), unless appropriately documented and justified as stated in the Manual;
- Dental work for cosmetic reasons or because of the personal preference of the patient;
- Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
- Adult orthodontics, except in conjunction with, or as a result of, orthognathic surgery;
- Placement of sealants for patients over 15 years old;
- Improper usage of panoramic X-rays (00330) along with intraoral complete series X-rays (00210).

Services Which Do Not Meet Existing Standards of Professional Practice

- Partial dentures provided prior to completion of Phase I restorative treatment which includes removal of all decay and subsequent fillings;
- Extraction of clinically sound teeth for the purpose of placing a partial denture;
- Infected teeth left untreated;
- Restorative fillings redone over a short time period without clinical indication;
- Restorative treatment of teeth that have a hopeless prognosis and should be extracted;
- “Unbundling” of procedures.

Section VI – Definitions

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

Activity Therapy

The evaluation and treatment of physical and psychosocial dysfunctions through the use of creative, manual, social, recreational, and educational activities to improve health and provide alternatives to drinking behavior and enable the individual to achieve an optimal level of self-care.

Ambulatory Services

Those diagnostic, preventive and rehabilitation services provided on a non-residential or outpatient basis to those suffering from alcoholism and alcohol abuse. Programs providing ambulatory services for alcoholism and alcohol abuse must be appropriately certified. Each program, including those operated by Article 28 facilities, must have an operating certificate issued pursuant to Article 31 by OASAS.

Carved-out Services

Special care services that are not included in the benefit package of a managed care provider, other than a duly authorized managed special care provider, for all current and future managed care enrollees, regardless of aid category.

Such services are long term services for individuals with chronic illnesses and include:

- day treatment and continuing day treatment programs;
- intensive psychiatric rehabilitation treatment programs;
- partial hospitalization;
- comprehensive Medicaid case management;
- rehabilitative (restorative) services provided to a resident of a residential program; and
- services provided to seriously, emotionally disturbed children in designated clinics.

Although clinic treatment services are not "carved-out-services", Comprehensive Outpatient Program (COPs) providers who have a contract with a managed care plan are entitled to "COPs only" reimbursement.

Chronic/Progressive

The physical, emotional and social changes that develop are cumulative.

Clinic Treatment Program

A planned combination of diagnostic and treatment services provided to developmentally disabled individuals and to collaterals who will be served intermittently for short periods of time (less than three hours).

The purpose of the services must be to maintain the individual in a less restrictive full-day program or to assist the individual in gaining admission to a less restrictive full-day program.

Clinic services are not to be used as substitutes for a full-day program.

Diagnostic and Treatment Center

An independent facility, not part of a hospital, which provides preventive, diagnostic, therapeutic, rehabilitative or palliative items or services by or under the supervision of a qualified physician and which is certified pursuant to Article 28 of the New York State Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis.

Article 28-licensed diagnostic and treatment centers may establish and operate part-time clinics pursuant to [10 NYCRR Section 700](#).

Emergency Room

A hospital-based department or organized service, which is certified by the New York State Department of Health to provide, by or under the direction of a physician, preventive, diagnostic, therapeutic treatment and to alleviate pain and suffering and conditions endangering life on an outpatient basis.

Additionally, the hospital must be qualified to participate under Medicare or be determined to meet participation requirements.

An exception will be made when a threat to the health or life of an individual requires the use of the most accessible hospital emergency room but such hospital does not currently meet Medicare participation requirements.

Hospital Outpatient Department

The department or organized service which is part of a hospital licensed under Article 28 of the New York State Public Health Law and certified by the New York State

Department of Health to provide preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a physician.

The outpatient department must comply with all applicable provisions of State law. The hospital must be approved as a qualified participant under Medicare or determined currently to meet the requirements of such participation.

Institutionalized Individual

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

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."

Medical Services

The services of physicians, nurse practitioners, licensed practical nurses, registered nurses, registered physician's assistants and other health care professionals licensed and certified by the Education Department to examine, evaluate, diagnose and treat the physical and psychiatric conditions of clients.

Such services include:

- physical examination for the purpose of identifying the nature and extent of substance abuse or dependence;
- physical examination to determine the nature and extent of any physical disease either related or unrelated to the individual's substance abuse or dependence;
- psychiatric evaluation to determine the nature and extent of mental disease or defect requiring attention.

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.

Nursing Services

The periodic and continuous evaluation services provided to an individual by registered professional nurses, as well as the provision of nursing care when appropriate.

Nutritional Services

Nutritional assessment and counseling and the provision of appropriate meals or nourishment to meet the dietary needs of the Programs' participants.

Ordered Ambulatory Services

An ordered ambulatory service is a specific service performed by a hospital or diagnostic and treatment center on an ambulatory basis upon the order of a qualified physician, nurse practitioner, physician's assistant, dentist, podiatrist or the appropriate staff of a clinic **not affiliated** with the hospital or diagnostic and treatment center which is providing the ordered ambulatory service (the ordered ambulatory provider).

The ordered ambulatory service is to test, diagnose or treat a Medicaid-eligible patient or a specimen taken from a Medicaid-eligible patient.

Such services may include a singular occasion of service or a series of tests or treatments provided by or under the direction of a qualified practitioner.

Personal Care/Self-Care Services

Services and activities designed to encourage, supervise, and assist individuals in performing personal hygiene and self-care activities at socially acceptable levels of performance.

Qualified Threshold Visit

A qualifying threshold visit is one where the registered clinic patient has an encounter with a physician, physician assistant, nurse practitioner or licensed midwife for services that include comprehensive primary care.

Routine Services

Services available on a daily or regularly scheduled basis which must be provided in accordance with individual service plans, including the following:

➤ **Medical Services**

Diagnosis and treatment by a physician of physical and mental conditions;

➤ **Nursing Services**

The assessment of nursing care needs and the provision of services by a registered nurse;

➤ **Psychological Services**

Assessment, therapy and behavioral interventions performed by a psychologist for the development of perceptual, sensorimotor, communication, social, emotional and cognitive skills, self-direction, and emotional stability;

➤ **Social Services**

The use of social-work methods oriented toward the identification, prevention, and management of an individual's personal and social problems which may interfere with his/her capacity to function within a normal social and economic environment.

Social Services

The use of social work methods oriented toward the identification, prevention, assessment and management of an individual's personal and social problems that may interfere with his/her capacity to function within a normal social and economic environment.

Special Services

Services which are provided upon specific written medical recommendation of the staff in accordance with individual service plans, including the following:

➤ **Audiological Services**

Assessment, treatment, counseling, and rehabilitation for the development and retention of hearing;

➤ **Dental Services**

Routine and emergency care of the mouth and teeth;

➤ **Medical Services**

Medical treatment requiring a specialist;

➤ **Occupational Therapy Services**

Assessment and treatment of physical and psychosocial dysfunctions for improvement in the level of self-care productivity;

➤ **Optometric Care**

Eye examinations and vision correction;

➤ **Pharmacy Services**

Preparation, storage, dispensing of and instruction in the use of medication;

➤ **Physical Therapy Services**

The prevention or treatment of neuromuscular or musculoskeletal disabilities

through assessment of a client's disability and rehabilitation potential;

➤ **Speech-Language Pathology Services**

Assessment, treatment, counseling and rehabilitation of expressive and receptive speech skills.

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