

**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 Which Cover the Care of Certain Medicaid Recipients May Have Other Qualifications for Participation and Offer Additional Services. If You are Interested in Participating in Managed Care, Information is Available at:

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

Section I - Requirements for Participation in Medicaid

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

Who May Provide Care

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

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

Physicians must be licensed and currently registered by the NYSED, or if in practice in another state, 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 New York State Medicaid.

Qualifications

The following outlines the qualifications required of practitioners for treating Medicaid recipients.

Qualifications of 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 New York State 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,

Qualifications of a Specialist

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, 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 after approval by a committee of the New York State Council of District Branches of the American Psychiatric Association appointed for this purpose by the President of the Council.

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 or the New York State 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 Medical Society of the State of New York or the New York State Osteopathic Society;
- ▶ Continuing education approved for this purpose by the Medical Society of the State of New York or the New York State 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 A.M.A., 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 Medical Society of the State of New York or the New York State Osteopathic Society.

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 licensee is entitled to practice medicine as though fully licensed, without supervision or other restriction. The DOH is responsible for monitoring the compliance with the practice requirement that limited license physicians practice in a medically underserved area. The 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 New York State 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.

Physician's Assistants

Services rendered by a registered physician's assistant must be in accordance with the provisions outlined in Article 131A of the New York State Education Law and Article 37 of the New York State 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 registered physician's assistants they employ are enrolled as *non-billing Medicaid providers*.

Physician's assistants 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 registered physician's assistant.

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

The services of physician's assistants will be reimbursed as follows:

- Payment will be made to the physician who employs the assistant;
- Payment will be according to the standard fees that physicians normally receive. This applies whether the physician, the employed physician assistant, or both individuals provide the service;
- The physician for a service may make no duplication or increase in charges, solely because an assistant has provided assistance. The one exception to this policy is "Physician Assistant Services for Assist at Surgery". See 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 physician's assistant and also the name and Medicaid provider identification number of the physician assistant who rendered the care.

Nurse Practitioners

Services rendered by a nurse practitioner must be in accordance with Sections 6902 and 6910 of the New York State Education Law. License requirements are established by the NYSED, and can be found at: <http://www.op.nysed.gov/nurse.htm>

The nurse practitioner must have a collaborative agreement and practice protocols with a licensed physician who is enrolled in Medicaid, and must enroll in Medicaid as a separate provider of service.

A physician may have collaborative agreements with no more than four nurse practitioners who are not located on the same physical premises as the physician. Nurse Practitioners may also enroll in the Preferred Physicians and Children Program (PPAC) and the Medicaid Obstetrical and Maternal Services Program (MOMS).

The services of nurse practitioners are reimbursable directly to the enrolled nurse practitioner or to the employing physician's group or multi-service group which employs him/her. In accordance with the provisions of the Education Law, nurse practitioners must have a collaborative agreement and practice protocols with a physician in order to provide medical care and services in a private office setting. Medicaid requires the physician with whom the nurse practitioner has his/her collaborative agreement to be enrolled in the Medicaid Management Information System (MMIS).

Nurse Practitioners may order medically necessary ancillary services and, if he/she has completed a pharmacological component of training, may write prescriptions for drugs in accordance with the above noted protocols.

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 the 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 Office of Medicaid Management (OMM), Bureau of Enrollment, 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 OMM, in writing, with the effective departure date.
- Send written notification to:

**New York State Department of Health
Office of Medicaid Management
Fee-For-Service Provider Enrollment Unit
150 Broadway, Suite 6E
Albany, NY 12204-2736**

If your group has not complied with these requirements, it must do so immediately.

- 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 (see subsequent section on **Liability**). *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 a physician assistant or certified social worker. In this situation, the physician assistant or the certified social worker must be identified.
- 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 as stated in this article. Additionally, the State Attorney General's Office will investigate egregious behavior.

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 **1-800-342-3750**.

Record Keeping Requirements

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

Physician Manual Policy Guidelines

- The full name, address and medical assistance program identification number of each recipient examined and/or treated in the office for which a bill is submitted;
- The date of each recipient visit;
- The recipient's chief complaint or reason for each visit;
- The recipient'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 recipient, including recipient'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 recipient 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, records on recipients must be maintained and be available to authorized Medicaid officials for six years following the date of payment.

Section II - Physician Services

Under the New York State Medicaid Program, physician services may be provided as medically indicated to eligible recipients.

Lead Screening Tests

All physicians who provide services to children are required to assess children between six months and six years of age for high dose exposure to lead and to screen or refer for lead screening those found to be at risk.

In addition, health care providers are required to screen or refer for blood lead screening all children at or around 1 and 2 years of age. Follow-up testing is also required for children identified with elevated blood lead levels

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.

Reproductive Health Services (Good Cause)

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

Circumstances in which the DOH must determine “good cause” not to bill health insurance involve situations where the billing could jeopardize the emotional or physical health, safety and/or privacy of the Medicaid recipient. These circumstances may arise when reproductive health services such as family planning, pregnancy-related services or treatment of sexually transmitted diseases are provided. When warranted, providers on behalf of their patients may request a “good cause” determination and an authorization for not billing the health insurance. If a particular patient wants the service to remain confidential, the provider must contact the DOH at (800) 541-2831 Monday through Friday, between 8:00am and 4:45 pm.

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

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

Family Planning, Including Sterilizations

Family planning services mean the offering, arranging and furnishing of 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 professional medical counseling, sterilization, insertion of Norplant, prescription drugs, non-prescription drugs and medical supplies prescribed by a qualified physician, physician's assistant or nurse practitioner. Family planning services do not include hysterectomy procedures. Medicaid does not cover treatment of infertility.

Offering of and arranging for family planning means providing services under the medical assistance program such as:

- Disseminating information, either orally or in writing, about available family planning health services;

- Providing for individual or group discussions regarding family planning health services; and
- Providing assistance by arranging visits with medical family planning providers.

Recipient Eligibility

All recipients 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 contact the DOH. (Please see **Information for All Providers, Inquiry**, for the appropriate telephone number.) Please obtain birth date, sex, social security number, or as much of this information as possible, before contacting the Department. If sufficient information is provided, Department staff will verify the eligibility of the individual for Medicaid.

Medicaid recipients enrolled in managed care plans (identified on MEVS as "PCP"), may obtain HIV blood testing and pre- and post-test counseling when performed as a family planning encounter from the managed care plan or from any appropriate Medicaid enrolled Provider without a referral from the managed care plan. Services provided for HIV treatment may only be obtained from the managed care plan.

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

Recipient Rights

Recipients are to be kept free of coercion or mental pressure to use family planning services. Also, recipients 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 Department of Health requirements for such Programs.

Sterilizations

Medical family planning services include sterilizations. Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing. Medicaid reimbursement is available for sterilization only if the following requirements are met.

Sterilization Requirements:

- a. **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."
- b. **Waiting Period** - The recipient 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 recipient signs the form is not to be included.
- c. **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.

- d. Minimum Age** - The recipient to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.
- e. Mental Competence** - The recipient must not be a mentally incompetent individual. For the purpose of this restriction, "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.
- f. Institutionalized Individual** - The recipient to be sterilized must not be an institutionalized individual. For the purposes of this restriction, "institutionalized individual" refers to an individual who is (1) 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 (2) confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
- g. Restrictions on Circumstances in Which Consent is Obtained** - Informed consent may not be obtained while the recipient 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 recipient's state of awareness.
- h. Foreign Languages** - An interpreter must be provided if the recipient to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.
- i. Handicapped Persons** - Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind or otherwise handicapped individuals.
- j. 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 recipient's choice is mandated by New York City Local Law No. 37 of 1977.
- k. Reaffirmation Statement (NYC Only)** - A statement signed by the recipient upon admission for sterilization, acknowledging again the consequences of sterilization and his/her desire to be sterilized, is mandatory within the jurisdiction of New York City.

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

Sterilization Consent Form

A copy of the New York State Sterilization Consent Form (DSS-3134) must be given to the recipient 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. A copy of the form and instructions for completion are included in the Billing Guidelines section of this Manual.

To obtain the **DSS-3134 Form**, in English and/or Spanish, write to:

**Office of Temporary and Disability Assistance
Forms and Print Management
PO Box 1990
Albany, NY 12201**

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 New York State Medicaid will not pay for services rendered illegally, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City. Any questions relating to New York City Local Law No. 37 of 1977, should be directed to the following office:

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

Hysterectomies

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 recipient 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 recipient is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

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

For hysterectomies, the requirement for the recipient'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 recipient 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 recipient 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. A copy of the form and instructions for its completion are included in the Billing Guidelines section of this Manual. To obtain the **DSS-3113 Form**, in English and/or Spanish, write to:

**Office of Temporary and Disability Assistance
Forms and Print Management
PO Box 1990
Albany, NY 12201**

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the Department of Health. Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

New York State Medicaid 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 New York State Medicaid Program. 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."

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.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to NYC beneficiaries. Payment for elective abortions is funded with 100% New York City funds.

The complete law can be found at:

<http://www.senate.state.ny.us/>

click on "Bills and Laws", search on "Laws of New York", and click on "Social Services Law".

Prenatal Care Assistance Program

Prenatal Care Assistance Program (PCAP) providers, certified by the DOH, provide a comprehensive package of prenatal care services through hospitals and clinics. PCAP providers may provide prenatal services either directly or through subcontract with qualified private physicians or agencies. The PCAP providers are reimbursed for all prenatal and postpartum visits, laboratory and ultrasound (sonogram) procedures. Administration of the Program is supervised by the DOH.

Providers interested in this Program may call the DOH at (518) 474-1911 for information or visit the Department's website at:

www.health.state.ny.us/nysdoh/perinatal/en/perinatalintro.htm

Patients should be instructed to call the Healthy Baby Hotline toll free at 1-800-522-5006 for information.

Medicaid Obstetrical and Maternal Services Program

Obstetricians, family physicians, nurse midwives and nurse practitioners who meet certain criteria may enroll in the Medicaid Obstetrical and Maternal Service (MOMS) program and receive increased fees for obstetrical care. A key component of the MOMS program is the requirement that obstetrical providers refer women to:

- Approved health supportive service providers such as hospital and free-standing clinics:
and,
- Home health and visiting nurse agencies for services such as:
 - ▶ Health education,
 - ▶ Psychosocial assessment and counseling,
 - ▶ Nutrition education,
 - ▶ The Women, Infant and Children Program (WIC), and,
 - ▶ Help with transportation and day care.

The health supportive service provider will also assist women with the Medicaid application process. Reimbursement for health supportive services is on a separate schedule and is not included in fees for obstetrical care.

For enrollment information as a health supportive service provider, please write to:

**Perinatal Health Unit
New York State Department of Health
Corning Tower Room 780
Empire State Plaza
Albany, New York 12237.**

For physician enrollment information, please contact:

**New York State Department of Health
Office of Medicaid Management
Provider Enrollment Unit
150 Broadway, Suite 6E
Albany, New York 12204-2726.**

For program information visit the Department's website at:

www.health.state.ny.us/nysdoh/perinatal/en/perinatalintro.htm

Obstetrical Services

Obstetrical care includes prenatal care in a physician's office or dispensary, delivery in the home or hospital, postpartum care and, in addition, care for any complications that arise in the course of pregnancy and/or the puerperium.

The following standards and guidelines are considered to be part of normal obstetrical care:

Antepartum Care

Under normal circumstances the physician should see the patient every 4 weeks for the first 28 weeks of pregnancy, then every 2 weeks until the 36th week and weekly thereafter, when this is feasible. As part of complete antepartum care, provision of the following laboratory and other diagnostic procedures is encouraged: Papanicolaou smear, complete blood count, complete urine analysis, serologic examination for syphilis and hepatitis, chest X-ray with proper shielding of the abdomen, and blood grouping and Rh determination with serial antibody titers, where indicated.

Intrapartum Care

Whenever possible, delivery should be performed in a hospital. In addition to these standards, the routine attendance of a qualified anesthesiologist at the time of delivery is recommended as an important preventive measure in promoting optimum medical care for both mother and infant.

Postpartum Care

Upon discharge from the hospital, the patient should be seen for a postpartum physical exam at 3 to 6 weeks and again in 3 to 6 months.

A Papanicolaou smear should be obtained during the postpartum period at one of the visits.

Other Medical Care

Consultation with specialists in other branches of medicine should be freely sought without delay when the condition of the patient requires such care.

Expanded Eligibility and Services for Pregnant Women and Infants

Income eligibility levels have been expanded for pregnant women and infants up to age one. Many pregnant women, who were previously not eligible, may now receive medical assistance.

To encourage early prenatal care, Medicaid application procedures for pregnant women have been simplified. Women are guaranteed eligibility, regardless of income changes, up to 60 days following the month the pregnancy ends.

Current income levels can be found on the Department's website at:

www.health.state.ny.us/nysdoh/perinatal/en/income.htm

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 you perform laboratory tests for your own patients and bill Medicaid for these services, you must fill out the form located at:

<http://www.health.state.ny.us/nysdoh/mancare/omm/0898clia.doc>

and submit the form to:

**New York State Department of Health
Office of Medicaid Management
Bureau of Provider Enrollment
150 Broadway, Suite 6E
Albany, New York 12204-2726**

In addition to the form, you must include a copy of:

- Your 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. You will be denied payment on claims for lab tests performed in your office if you failed to provide Medicaid with the necessary CLIA information.

The payment system has linked lab test procedure codes to the type of CLIA certification as follows.

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.

Mandatory Generic Drug Program

As of October 1, 2002, the Medicaid Program began requiring a prior authorization for brand name drugs when there is an A-rated generically and therapeutically equivalent product available.

The Commissioner of Health has exempted specific brand-name drugs from prior authorization. There is also a process to request that other brand-name drugs be exempt for all Medicaid recipients.

The following brand-name drugs, which have a generic available, may be prescribed without prior authorization:

Coumadin®	Gengraf®	Sandimmune®
Clozaril®	Lanoxin®	Tegretol®
Dilantin®	Neoral®	Zarontin®

If a generic drug is prescribed, no additional actions will be required. However, when writing a prescription for a brand-name drug that has a generic available, the prescriber will need to call the prior authorization line. The prior authorization number that is assigned must be

written on the prescription or Medicaid will not reimburse the brand-name drug. The pharmacist will also need to validate the prior authorization number before submitting the claim.

A special edition of the Medicaid Update is available which provides detailed instructions on the new program, and answers to common questions for physicians, other prescribers, and pharmacists. The information is available on the DOH website at:

<http://www.health.state.ny.us/nysdoh/manicare/omm/2002/oct2002supp.htm>

How to Obtain a Prior Authorization

Listed below are the general guidelines for prescribers about the Mandatory Generic Drug Program. Following the guidelines is the Prior Authorization Worksheet with step-by-step instructions on completing the call, and the exact questions that will be asked when you make the phone call to obtain a prior authorization.

1. Generic drugs do not require prior authorization. Only brand-name drugs with an A-rated generic require prior authorization.
2. The prescriber must call the Prior Authorization Call Line to initiate the prior authorization process.
3. Once approval has been given and a prior authorization number is obtained, the prior authorization number must be written on the prescription and documented on the Prior Authorization Worksheet.
4. The patient's medical record must include documentation of the patient's need for a brand, rather than a generic drug (e.g., allergic reaction to the generic product's inactive ingredients, adverse reaction to generic product's inactive ingredients, etc.). In addition, the completed prior authorization worksheet must be included in the patient's medical chart.
5. Prior authorization is required for each specific prescription, not for specific patients. It is effective for up to six months. Each time a new prescription is written for the brand-name drug when a generic equivalent is available, a new prior authorization must be obtained, and the new prior authorization number written on the prescription.

6. An agent of the prescriber (an employee such as a medical assistant) may complete the prior authorization call and write the prior authorization number on the prescription.
7. If a prior authorization number is not on a prescription for a brand-name drug which has a generic equivalent, the pharmacy will be prohibited from filling the prescription. The pharmacy will need to contact the prescriber to ask that the prior authorization process be completed, or that the prescription be changed. If this does not occur, the patient may have to return to your office, or call your office to get the necessary prior authorization number.
8. Prescriptions for brand-name drugs will continue to require “DAW” and “Brand (Medically) Necessary” on the prescription in the prescriber's own handwriting, **in addition to the prior authorization number**. These requirements are mandated by State and Federal law.

For billing questions, contact 1-800-343-9000.
For clinical or policy questions, contact the
Pharmacy Policy and Operations Staff at 518-486-3209

**NEW YORK STATE MEDICAID PROGRAM
BRAND-NAME PRIOR AUTHORIZATION INDIVIDUAL PATIENT REQUEST
PRESCRIBER WORKSHEET**

Prior Authorization Call Line 1-877-309-9493

Brand-name drugs with an A-rated generically and therapeutically equivalent product (as determined by the FDA) must be prior authorized effective November 17, 2002. A voice interactive call line is utilized to obtain prior authorization when appropriate.

The following drugs are exempt from the mandatory generic requirement and do not require prior authorization:

Coumadin® Dilantin® Neoral® Gengraf® Sandimmune®
Clozaril® Lanoxin® Tegretol® Zarontin®

A. PRESCRIBER IDENTIFIER

Ordering Practitioner Medicaid ID number
OR
NYS Physician/PA/Resident
NYS Optometrist
NYS Nurse Practitioner/Midwife
NYS Dentist
NYS Podiatrist
OR
Out-of-State Prescriber License

Complete one of the following prescriber identifiers:

MMIS ID Number _____
OR
00 _____
U _____ or V _____
F _____
000 _____
0000 _____
OR

(Use your state abbreviation in the first two spaces.)

B. CLIENT IDENTIFICATION NUMBER (2 letters, 5 numbers, 1 letter)

C. BRAND-NAME DRUG

D. REASON BRAND-NAME DRUG IS REQUIRED

The patient's medical record documents the following primary reason for the brand-name prescription.

(Indicate the number that corresponds with the primary reason the brand-name drug is required)

1. Allergy to generic drug inactive ingredient(s)
2. Adverse reaction to generic drug inactive ingredient(s)
3. Documented history of successful therapeutic control with brand-name drug

Record the prior authorization number here for your records and on the top of the patient's "BRAND" prescription. REMEMBER YOU MUST ALSO WRITE "DAW" AND "BRAND (MEDICALLY) NECESSARY" ON THE PRESCRIPTION.

INSTRUCTIONS ON NEXT PAGE

**NEW YORK STATE MEDICAID PROGRAM
BRAND-NAME PRIOR AUTHORIZATION INDIVIDUAL PATIENT REQUEST
PRESCRIBER INSTRUCTIONS**

Prior Authorization Call Line 1-877-309-9493

- ◆ Prescriber writes prescription for brand product, designates "DAW" and writes "Brand (Medically) Necessary".
- ◆ Prescriber or agent calls 1-877-309-9493. Information can be entered either by voice or by using the phone keypad.
 - ◆ Choose the Brand-Name Prior Authorization - option '3'.

A. PRESCRIBER IDENTIFIER:

Choose Prescriber Option

Residents and physician assistants must use the MMIS/License number of their supervising physician. Do not use a hospital/clinic or group MMIS number.

- ◆ Enter your personal Medicaid identification number (MMIS)

OR

- ◆ License Number

- ⓪③ Choose '1' for Physician/Physician Assistant/Resident
- ⓪③ Choose '2' for Optometrist
- ⓪③ Choose '3' for Nurse Practitioner/Midwife
- ⓪③ Choose '4' for Dentist
- ⓪③ Choose '5' for Podiatrist

B. CLIENT IDENTIFICATION NUMBER_ - Enter the patient's Medicaid client identification number (2 letters, 5 numbers, 1 letter). Follow the prompts.

C. BRAND-NAME DRUG_ - Clearly state the name of the brand-name drug you are prescribing.

D. REASON BRAND-NAME DRUG IS REQUIRED:

Enter the medical reason you are prescribing the brand-name drug, rather than the generic.

1. Allergy to generic drug inactive ingredient(s)
2. Adverse reaction to generic drug inactive ingredient(s)
3. Documented history of successful therapeutic control with brand-name drug

- ◆ **A prior authorization number will be returned; write it legibly on the face of the prescription.**

- ◆ Do not fax a copy of this worksheet, it should be kept in the patient's medical chart for future reference.

- ◆ Phone or fax prescriptions are allowed, but the original prescription, with the prior authorization number written on the prescription, must be sent to the pharmacy within five business days.

The Brand-Name Prior Authorization Worksheet should be reproduced for future prescribing. It will also be available on the Department's website, <http://www.health.state.ny.us>, click on "Information for Providers", then "Medicaid", then "Medicaid Mandatory Generic Drug Program".

For billing questions, contact 1-800-343-9000.

**For clinical concerns or policy questions, contact the
Pharmacy Policy and Operations Staff at (518) 486-3209.**

Prior Authorization is NOT necessary for:

1. A generic drug.
2. A brand-name drug when there is no 'A' rated generic.
3. A brand-name drug **without** "DAW/Brand (Medically) Necessary" written on the prescription. The patient will receive the generic product.

The Physically Handicapped Children's Program

Only physicians who qualify for the DOH, Office of Health Systems Management specialty ratings may be approved to render Physically Handicapped Children's Program (PHCP) covered services to children under the PHCP. To qualify for reimbursement, physicians must be listed in the Office of Health Systems Management Roster of Medicaid Specialists.

Preferred Physicians and Children Program

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

- Encourages the participation of qualified practitioners;
- Increases children's access to comprehensive primary care and to other specialist physician services; and,
- Promotes the coordination of medical care between the primary care physician and other physician specialists.

Administration of the PPAC program is supervised by the DOH.

Physician Eligibility and Practice Requirements

The qualified primary care physician will:

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

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

Such physician will submit at the time of application, (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a curriculum vitae; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

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

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

- Provide 24-hour telephone coverage for consultation;

This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients. This requirement cannot be met by a recording referring patients to emergency rooms.

- Provide medical care coordination;

Medical care coordination will include at a minimum: the scheduling of elective hospital admissions, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, and scheduling for necessary ancillary services.

- Agree to provide periodic health assessment examination in accordance with the standards of Medicaid;
- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;
- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

The qualified non-primary care specialist physician will:

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

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

Such physician will submit at the time of application, (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) where applicable, **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a curriculum vitae; proof of medical

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

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

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

- Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultant visit;
- Notify the primary care physician when scheduling hospital admission;
- Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;
- Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with 30-day notice by either party.

Recipient Eligibility

PPAC visits/examinations may be claimed for Medicaid recipients whose ages range from birth through twenty (20) years.

Covered Services

For the PPAC participating provider the visit/examination is the only service claimed and reimbursed through PPAC. Claiming is by evaluation and management codes specific to place of service, such as office. The PPAC participating provider may NOT bill for (a) physician services provided in Article 28 clinics and (b) contractual physician services in emergency rooms.

Claims for physician services other than the visit/examination will continue to be claimed and reimbursed in accordance with the instructions outlined in this Manual.

Application For The Preferred Physicians and Children Program

Physicians may apply to participate in the PPAC program by completion and submittal of the State Department of Health form, "Application for Enrollment as a Medical or Dental Specialist", and **the Addendum**, which constitutes application/agreement to participate in the Medicaid PPAC program. These forms must be completed and

submitted by physicians already enrolled in Medicaid as well as by first-time applicants, and by those applying for reenrollment.

Forms necessary to apply to become a Medicaid and/or PPAC provider may be obtained by written request to:

**New York State Department of Health
Office of Medicaid Management
Bureau of Provider Enrollment
150 Broadway, Suite 6E
Albany, N.Y. 12204-2726.**

PPAC Procedure Codes are in the Procedure Code and Fee Schedule Section of this manual.

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.

To obtain HIV-EFP enrollment forms, physicians' written requests should be sent to:

**New York State Department of Health
Office of Medicaid Management
Bureau of Provider Enrollment
150 Broadway, Suite 6E
Albany, New York 12204-2726**

Medicaid Payment for Rapid HIV Testing

In concert with the federal Centers for Disease Control and Prevention, the New York State Department of Health, including the Medicaid program, supports the use of rapid, technologically simple devices, such as the OraQuick® rapid HIV test, 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:

John Schnurr
HIV Ambulatory Care Administrator
New York State Department of Health
AIDS Institute
Room 459 Corning Tower
Albany, NY 12237
Phone: (518) 473-3786
Fax: (518) 473-8905
E-Mail: jjjs09@health.state.ny.us

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, must hold certification appropriate for CLIA categorization of the test device being used and must be registered with Medicaid as a Physician Office Laboratory (POL). To date, the OraQuick® rapid HIV test is the only HIV test device categorized as waived; the OraQuick® device requires minimally a CLIA certificate of waiver, but may be performed under any level of certification.

Physicians may apply for a CLIA certificate by contacting the Physician Office Laboratory Evaluation Program at (518) 485-5352 for an application form. The application is also posted on the Centers for Medicare and Medicaid Services' website: <http://www.cms.hhs.gov/clia>. Select the option "How to Apply for a CLIA Certificate: Form CMS-116." 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 fill out the POL-CLIA information form below.**

The completed enrollment form must be submitted to the address listed at the top of the completed form.

**Office of Medicaid Management
New York State Department of Health
Fee for Service Provider Enrollment
150 Broadway, Suite 6E
Albany, New York 12204**

PHYSICIAN OFFICE LABORATORY-CLIA INFORMATION

INSTRUCTIONS:

1. Please print or type all required information.
2. A **SEPARATE** form must be submitted for **EACH** eligible physician in a group. If a physician works at multiple physician office laboratory sites, a **SEPARATE** form must be submitted for **EACH SITE**.
3. Attach a copy of the most recently issued valid Clinical Laboratory Improvement Amendments (CLIA) certificate for your site. If your physician office laboratory does not currently have a CLIA certificate, please contact the New York State CLIA unit at (518) 485-5352.
4. A letter of verification from the Centers for Medicare & Medicaid Services (CMS) or the New York State Department of Health's CLIA unit is also acceptable evidence of CLIA certification. To obtain a letter from the New York State CLIA unit, please call (518) 485-5352.

New York State Medicaid Provider ID Number: _____

CLIA Certificate Number: _____

Physician License Number: _____

Physician Name: (LAST) _____ (FIRST) _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number (_____) _____ - _____.

Please check the appropriate box for the type of CLIA Certificate held for this site: (check one):

- Waiver PPMP Registration Compliance/Accreditation
(Provider Performing
Microscopy Procedures)

This item should be completed by legally organized group practice(s) only:

NYS Medicaid Provider ID Number for Group (if applicable): _____

Name of Group Practice: _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

DOH-4124 (4/04)

Methadone Maintenance Treatment Program

A Methadone Maintenance Treatment Program 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 methadone-maintenance programs.

Authorization to conduct a methadone-maintenance program 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 New York State Office of Alcoholism and Substance Abuse Services may require additional accreditation. Only narcotic addicts may participate in Methadone Maintenance Treatment Programs.

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.

Scope of Services

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

Comprehensive Medicaid Case Management Programs

Comprehensive Medicaid Case Management (CMCM) programs are targeted to specific segments of the Medicaid population who require focused effort to improve access to a wide range of medical, social and other support services for the purpose of improving clients' independent functioning in the community. While new target groups may be added, the following presents the existing service populations for CMCM:

- Pregnant and parenting teens. The primary targeted group may consist of any adolescent, male or female, less than 21 years of age, who is Medicaid eligible and is a parent residing in the same household with his or her child(ren) or is pregnant. The target group may vary by local social services district. The local department of social services determines entry into the program.
- Mentally retarded and developmentally disabled individuals who need comprehensive rather than incidental service and who reside in Family Care

Homes, Community Residences, live independently or with family. The Office of Mental Retardation and Developmental Disabilities Revenue Management Field Offices determine entry into the program.

- Seriously mentally ill individuals who require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community. A local committee consisting of the County Mental Health Department and other human services providers determines entry into the program.
- Segments of the HIV+ and at risk population as follows: women of child bearing age who are HIV+, women referred by hospitals participating in the Obstetrical HIV Counseling Testing Care initiative or who are at high risk of HIV infection, HIV+ children and adolescents through 20 years of age, HIV+ clients receiving community based case management in Community Services Programs, Community Based Organizations or other organizations under contract to the AIDS Institute to provide other services. Family members and co-residents of the targeted clients may also receive case management services. Entry into the program is determined by the case management provider organization.
- Poor women of childbearing age who are pregnant or parenting and infants under one year of age who reside in designated areas of the state where there is high infant mortality. (Sections of New York City and Syracuse.)
- Developmentally delayed infants and toddlers. The target group consists of infants and toddlers from birth through two years of age who have, or are suspected of having, a developmental delay, or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down's Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome. These children and their families require ongoing and comprehensive rather than incidental case management (service coordination). Entry into this program is determined by the designated municipal early intervention agency in accordance with the regulations of the Department of Health.

The local department of social services has the names and contact numbers for all CCMCM providers serving clients within their district. **Note: Not all local departments of social services have all of the above programs.**

Section III - Basis of Payment for Services Provided

Payment for physician services will not exceed the maximum fee established by the Department of Health and promulgated by the New York State Director of the Budget. The *Procedure Code and Fee Schedule* lists the fees for physician services.

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.

Limitations on Payment

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

Reimbursement is **not** available to a physician salaried/compensated by a facility (e.g., hospital, diagnostic and treatment center), *unless* that portion of the physician's salary/compensation apportioned to patient care (as contrasted to administration, teaching and research responsibilities) is excluded as an element of cost in the determination of the facility's Medicaid rate.

Medicaid reimbursement is available to a physician for medical services provided in an office, home, hospital, 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 third-party 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 recipient. 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 recipient. 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.

The cost of the New York State triplicate Prescription Form is covered in the evaluation and management service fee.

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

Physicians who are enrolled in Medicaid may not refuse to provide services to a Medicaid recipient because of third-party liability for payment for the service, **nor may they bill a patient with Medicare coverage for the Medicare coinsurance or deductible amounts.** Furnishing or ordering medical care, services or supplies that are substantially in excess of the recipient's needs may result in recoupment of the cost of those services, drugs or supplies from the ordering physician.

Payment cannot be made for medical care if the original claim is received more than two years after the original date of service. The only acceptable exceptions to this policy are:

- Errors by the Department;

- Errors by a local social services district, or another agent of the Department; or,
- Court ordered payments.

Physicians resubmitting claims after two years from the date of service should be maintaining documentation showing that the original submittal was within two years and that the submittal was either within 90 days or showing circumstances justifying waiver of the 90-day submission. Refer to **Information for All Providers, General Billing** for more information.

When you encounter a situation where you historically have not received an insurance payment either directly or through the cooperation of a Medicaid recipient or a legally responsible relative, you can receive that payment by following these steps:

- Contact the Third Party Resources worker in the local department of social services, which is fiscally responsible for the Medicaid recipient/patient.
- Advise the Third Party worker that you would like to be paid directly by the insurance carrier for your claims because the legally responsible relative or Medicaid recipient has been uncooperative in the past in paying you the insurance payment that they received for your service. You will need to identify the Medicaid recipient who is being treated in order for the local social services district to assist you.
- The Third Party worker will complete and furnish you with two forms, *An Authorization to Act as Agent* and *Subrogation Notice to Insurance Carrier*.
- In addition to assuring receipt of payment for your services, your cooperation in billing the insurance company could provide you with a higher reimbursement rate than the Medicaid rate for the same service.

In an effort to expedite access to primary care for pregnant women and children and timely provider reimbursement, *an exception is made to the policy described above* concerning pursuit of payment from third party resources. 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 the diagnosis codes listed below 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. The diagnosis codes involved are as follows:

Regardless of Age

V22.0
V22.1
V23.0-V23.9

Recipient is Under Age 21

V01.0-V07.9
V20.0-V20.2
V70.0

V28.0-V28.9
640.0-648.9 if the fifth digit is 3
651.0-658.9 if the fifth digit is 3
671.0-671.9 requires a fifth digit
673.0-673.8 requires a fifth digit
675.0-676.9 requires a fifth digit

V72.0-V72.3
V73.0-V75.9
V77.0-V77.7
V78.2-V78.3
V79.2-V79.3
V79.8
V82.3-V82.4

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 New York State 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.

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*. (Vaccine codes are noted herein in the *Medicine* section, under the heading, *Immunization Injections*.)

Vaccines are available without charge and are distributed in New York through the New York VFC Program, administered by the Department of Health.

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 current Medicaid administration fee for VFC-provided vaccine is \$17.85 per immunization, i.e. per vaccine code. The appropriate Evaluation and Management Service may also be billed.

Call 1-800-KID-SHOTS (1-800-543-7468) to obtain VFC information and/or registration material.

When claiming for immunization procedures for Medicaid eligibles less than nineteen (19) years of age, charge the administration fee of \$17.85 per immunization. When claiming for these procedures for Medicaid eligibles ages nineteen (19) or over, enter the cost to you of the vaccine used for the patient plus \$2.00, which covers the administration fee. You will be paid, for persons ages nineteen (19) or over, the \$2.00 administration fee plus the lower of your cost or the monthly fee on file for the date the immunization was administered. The appropriate Evaluation and Management Service may also be billed.

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. Radiographic studies requiring fluoroscopic examination are identified in the Procedure Code Section of the Manual. 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 Radiology Services

In order to be paid for both the professional and the technical and administrative components of a radiology service, physicians who provide radiology services in their offices must:

- Perform the professional component;
- Own or directly lease the equipment; and,
- Supervise and control the radiology technicians who perform the radiology procedures, or

- Be employees of physicians who own or directly lease the equipment and must supervise and control the radiology technicians who perform the radiology procedures.

Note: No payment will be made to a qualified practitioner solely for the technical and administrative component of a radiology service.

This policy applies to all radiology services, including Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET).

Reimbursement for Magnetic Resonance Imaging

Medicaid coverage of magnetic resonance imaging (MRI) services has been expanded to include reimbursement to physicians for either the complete procedure or the professional component. The maximum reimbursable amount for an MRI service is \$500 for the complete procedure (including both the professional and technical/administrative components). For information regarding the correct billing for the professional or technical/administrative components, see the Radiology Section of the Billing Guidelines.

Reimbursement for paramagnetic contrast media is made via **code A4647 Supply of paramagnetic contrast material, e.g., gadolinium (per ml)**.

When billing for only the professional component, it is imperative that the physician's claim be billed with the appropriate modifier (Modifier 26). Absence of the "26" 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.

General Standards for Care

Ophthalmologic care may be provided by a qualified ophthalmologist in his/her office, in clinics, in general or chronic disease hospitals, or in approved medical institutions or facilities.

A complete examination by an ophthalmologist must include the following components and any additional study and medical evaluation, including the use of drugs, necessary to arrive at a medical diagnosis:

- Case history;

- Internal and external eye examination;
- Vision correction;
 - ▶ Objective
 - ▶ Subjective (distance and near)
- Binocular coordination testing (distance and near);
- Gross visual fields (by confrontation);
- Tonometry for patients age 35 and over and for others where indicated.

Examinations for visual defects and/or eye diseases shall be provided to recipients only as necessary and as required by the individual's condition.

When an ophthalmologist determines that a patient needs his/her eyes examined at more frequent intervals than usual (every two years), he/she must write in the procedure description field of the claim form a brief report of the individual's condition and a recommendation concerning the scope and frequency of anticipated service.

Eyeglasses shall be provided only on the basis of a proper examination by and written prescription of a qualified ophthalmologist or optometrist. Furthermore, except in rare cases eyeglasses shall not be prescribed or provided for a recipient unless the initial correction or change in correction is at least .50 diopter. Prior approval must be obtained for any exception to this standard. A proper record of the examination, including any prescriptions for eyeglasses and other corrective appliances, must be kept.

Bifocals should be prescribed when eyeglasses are required for both distance and near vision unless the recipient has a medical condition that makes bifocal inadvisable. Two pairs of eyeglasses rather than bifocals will not be provided for reasons of personal preference.

Prior Approval

Prior approval by the DOH must be obtained for:

Contact lenses and the replacement of contact lenses;

- Tinted lenses;
- Visual Rehabilitation;

- Case-hardened industrial safety lenses; and
- Orthoptic training.

The professional who provides the services or item must request the approval. Prior approval for orthoptic training will not be valid for more than six months. In order to renew approval after six months, a treatment plan must be submitted outlining the progress already made along with a prognosis for the future.

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 recipient should share information regarding the patient's status with his/her source of primary medical care.

Medical Records to be Maintained

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 ICD-9-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.

Required Medical Record Documentation for Supervising/Teaching Physicians for Reimbursement

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.

Teaching physicians had been previously instructed that:

- 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 recipient 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 as described in the examples that follow.

Examples of Acceptable and Unacceptable Documentation

E/M Service	Minimally Acceptable Documentation by Teaching/Supervising Physician	Unacceptable Documentation by Teaching/Supervising Physician
<p>Hospital Admission</p>	<p>“I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s notes and agree with the documented findings and plan of care” (accompanied by countersignature).</p>	<p>“Agree with above” (accompanied by countersignature).</p> <p>“Seen and agree” (accompanied by countersignature).</p>
<p>Follow-Up Visits</p>	<p>“Hospital Day #3 - I saw the patient and evaluated his progress. I agree with the findings and plan of care documented in the resident’s notes” (accompanied by countersignature).</p> <p>- or -</p> <p>“See resident’s notes for details. I saw and evaluated the patient and agree with the resident’s findings and plans as written” (accompanied by countersignature).</p> <p>-or-</p> <p>“I saw the patient with the resident and agree with the resident’s findings and care plan” (accompanied by countersignature).</p>	<p>“Rounded, Reviewed, Agree” (accompanied by countersignature).</p>

Physicians are reminded that, 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.

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.

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 such as First DataBank 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 Medicaid 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.* Regardless of whether 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.*

Medicaid reimbursement may not exceed 125% of the Maximum State Medical Fee Schedule amount.

Based on prior agreement, the billing surgeon will apportion the total payment in relation to the responsibility and work done.

Reimbursement of Physicians for Services Rendered In a Hospital or Clinic

Employees of Diagnostic and Treatment Centers are not eligible to receive “fee-for-service” payment as individual providers for services provided in the clinic. The costs of physician services are included in the calculation of the Medicaid threshold visit rate which is the rate paid by the Medicaid Program to the center.

Physicians may be eligible for reimbursement as a “fee-for-service” provider if they provide a service and the clinic rate does not include this service. Reimbursement for these services can only be made to the individual practitioner and not to the clinic or a group owned by the clinic.

Employees of a hospital may or may not be eligible to receive “fee-for-service” payments. The determination is based on whether physician costs are included in the Medicaid rate paid to the hospital for patient services, and is documented (in your Medicaid enrollment file) with a letter signed by the facility’s chief financial officer which explains the complete details of how physician costs are reported in the hospital’s Institutional Cost Report.

Physicians or other practitioners may not bill the Medicaid program for a \$30 “office visit” for a service rendered in a hospital or clinic. Services rendered in hospital inpatient or outpatient settings, if billable based on the preceding paragraph, may be billed only with the appropriate hospital visit.

Exception to the above may exist where a physician orders in excess of \$75,000 in ambulatory services. These services may include pharmacy, laboratory services and durable medical equipment. If a physician reaches this amount for ordered services, the physician may be required to enroll as a non-biller. The Department of Health will determine if enrollment is required and the physician will be sent an application with an explanation of why enrollment is necessary.

Reimbursement for Ultrasonic Bone Growth Stimulators

Reimbursement is now available for ultrasound bone growth stimulators when medically necessary, prior approved, and ordered by a board certified or board eligible orthopedic surgeon for non-union fractures of the tibial shaft as evidenced by the following:

- An assessment of why the fracture is non-union (inadequate blood supply, etc.)
- No evidence of healing based on a minimum of three sequential monthly examinations
- At least 50% of the fracture surfaces are in apposition
- No more than ten degrees of anterior or posterior angulation
- No more than fifteen degrees of lateral angulation in either varus or valgus, and
- Other contributing factors that would affect bone growth such as age, smoking, etc.

Under no circumstances will ultrasound bone growth stimulation be approved for true synovial synarthrosis.

The maximum reimbursable amount for use of the system for the entire treatment period is \$2,000, including any integral parts or service, and can be claimed using **E0760**, osteogenesis stimulator, low intensity ultrasound, non-invasive.

In order to assess the benefit of this treatment modality on patient outcome and whether Medicaid resources are being spent wisely, follow-up on the status of patients who have used this system will be done.

For prior approval requests that are approved, the following information is required for submission at the time the non-union is healed or when other interventions are initiated (surgery, etc.):

- Summary of patient progress
- Copy of the most recent pertinent x-rays
- Patient's final disposition

Qualified Social Worker Services

For purposes of this section, the term "qualified social worker" means a person authorized pursuant to the Education Law to use the Title "certified social worker." The term "social worker" as used in this section refers to a qualified and currently licensed

social worker. The term "supervising psychiatrist" refers to a qualified psychiatrist as defined earlier in this section.

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. Services provided by social workers employed by a psychiatrist in private practice may not be reimbursed when provided to children in child caring institutions such as foster care or day care.

Payment for services performed by a social worker for a Medicaid recipient who is not a Qualified Medicare Beneficiary (QMB) (see "NOTE" below) may be made only to the psychiatrist for services which the social worker is qualified to perform. Social workers providing services to Medicaid recipients (who are not QMBs) may not bill independently for their services.

Although Medicaid does not reimburse for services provided by social workers to Medicaid recipients 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. Please see the *Clinical Social Worker Provider Manual* for details regarding these services. The local department of social services determines QMB eligibility.

Utilization Threshold

Under the Utilization Threshold Program, it will be necessary for providers to obtain an authorization from MEVS to render services for physician, clinic, laboratory, pharmacy and dental clinic care. This authorization to render services will be given unless a recipient has reached his/her utilization threshold limits.

When a recipient has reached his/her utilization threshold limits, it will be necessary for an ordering provider to submit a special *Threshold Override Application* form in order to obtain additional services. In certain special circumstances, such as emergencies, providers do not have to receive authorization from MEVS. (See special instructions in the Billing Guidelines Section of this manual.)

Arrangements have also been made to permit a provider to request a service authorization on a retroactive basis. In requesting a retroactive service authorization, you risk your request being denied if the recipient has reached his/her limit in the interim.

After you receive an authorization, your claim may be submitted to our Fiscal Agent for processing. The regulation requiring claims to be submitted within 90 days of the date of service still applies.

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

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

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

- "Managed care services" furnished by or through a managed care program, such as a health maintenance organization, preferred provider plan, physician case management program or other managed medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program. An exception to this would be if dental services are being provided by academic dental centers;
- 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. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease and pregnancy and pelvic abnormalities;
- Child/Teen Health Plan 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, hospital outpatient department, or free-standing diagnostic and treatment center; and
- Primary care services provided by a pediatrician or pediatric clinic.

The numbers of visits, lab procedures, medical supplies, drugs, and other items for each provider type are found in the General Policy Section under Information for All Providers.

Edit Messages of Particular Interest

Edit 01154 - No UT Service Authorization Record On File - This edit fails when a Utilization Threshold (UT) service authorization record is not on file at the time a claim is initially processed. If the provider obtains the UT service authorization via the Medicaid Eligibility Verification System (MEVS) while the claim is pending for edit 01154, the UT will be found during the claim recycling process, and the claim will be adjudicated in a subsequent remittance statement. Do not resubmit pending claims.

Edit 01155 - UT Service Authorization Exhausted - This edit may occur when, for example, a lab or pharmacy obtains a partial approval and bills for more procedures/items than authorized via MEVS. This edit may also occur, for example, when a provider has already been paid for this procedure/item or clinic visit. When a claim pends for this edit, the provider should review previous remittance statements to determine if the service has already been paid. If the service has not been previously paid, and if the provider obtains the UT service authorization while the claim is pending for edit 01155, the UT will be found during the claim recycling process, and the claim will be adjudicated in a subsequent remittance statement. Do not resubmit pending claims.

Please be aware that remittance statements are held for approximately two weeks prior to mailing. Therefore, providers who did not correctly obtain the necessary UT service authorizations prior to billing will not see claims change from pending to adjudicated status for at least two subsequent remittance statements after obtaining the UT service authorization.

Recipient Restriction Program

Recipients who have been assigned to a designated physician are required to receive all primary care from the selected provider as a condition of the Recipient Restriction Program (RRP). All claims from other physicians or clinics will be denied except under the following circumstances:

- In cases of documented emergencies where the emergency field of the claim form is appropriately marked;

- In cases where the primary physician has referred a recipient to another physician or clinic and the referring provider ID number field of the claim form is appropriately completed; and
- In cases where the service provided is either methadone maintenance or a service provided in an inpatient setting.

Restricted Recipient Program: Ordered Services

Restricted recipients may only receive certain ancillary services if they are ordered/prescribed by their primary provider. Primary physicians must order/prescribe the following services for recipients restricted to their practice: laboratory, durable medical equipment and pharmacy. The only exception to this policy is when a primary physician refers a restricted recipient to another provider for services. The provider to whom the recipient was referred may also order ancillary services, however, the servicing provider must enter the MEDICAID provider number of the patient's primary physician on all order/prescription forms.

Primary physicians must also order all non-emergency transportation services. Providers to whom a recipient is referred may not order non-emergency transportation services.

When a recipient is restricted to a primary inpatient hospital, that individual must receive all non-emergent inpatient hospital services from his/her designated inpatient provider. These recipients will also be restricted to a primary physician or clinic with admitting privileges to the primary inpatient facility. The primary physician or clinic is responsible for ordering non-emergent inpatient hospital services for a restricted recipient who is also restricted to a primary inpatient hospital. Recipients who are restricted to one inpatient facility may also be admitted to another hospital in cases of emergency or when referred by their primary provider.

As of April 1, 1993, services provided to restricted recipients are also subject to all utilization threshold limitations. It is the responsibility of the primary physician to complete and submit all Utilization Threshold Override Applications for restricted recipients when necessary.

Restricted Recipient Program: Referrals

Primary providers may refer restricted recipients to other providers when necessary. When doing so, the primary physician must give the servicing provider his/her MEDICAID provider identification number so that the servicing provider can perform the necessary MEVS steps and properly submit claims.

Restricted Recipient Program: Management Fee

Medicaid pays all primary physicians participating in the RRP a monthly management fee per restricted recipient. To collect this monthly fee, primary physicians must submit a claim through MEDICAID for each restricted recipient. The fee is payable, provided the recipient remains eligible, even though services may not have been rendered during the month. If a primary physician is no longer designated as patient's primary provider, the monthly management fee is no longer reimbursable. Primary physicians submitting claims for the monthly management fee should bill in the normal manner using procedure code **W0140** and using the first date of each month as the date of service.

Section IV - Definitions

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

Diagnostic Ultrasound Services

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

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 who is employed by a hospital or diagnostic and treatment center.

Medicine Services

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

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 a recipient or a specimen taken from a recipient. 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" were previously known as "Referred Ambulatory Services."

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.

Section V - Unacceptable Practices

All services ordered for Medicaid recipients must be medically necessary and related to the specific complaints and symptoms of the patient. The State may take administrative action against ordering providers who cause unnecessary utilization of services by inappropriate ordering. Further, the State may seek restitution for monetary damage to the Program resulting from inappropriate and/or excessive ordering of services.

For the definition and general discussion of unacceptable practices, see **Information For All Providers, General Policy**. The following discussion and examples of unacceptable practices are specific to the relationship between an ordering practitioner and a service provider.

Examples of Unacceptable Practices:

- **Undocumented necessity**
When an ordering provider fails to document properly the specific need for ordered items or supplies in a patient's medical record, or, when a practitioner furnishes or orders medical care, services or supplies substantially in excess of a recipient's medical needs, the State may require repayment from the person furnishing the excessive services, from the person under whose supervision they were furnished, or from the person ordering the excessive service.
- **Bribes and kickbacks**
Social Services Regulations 515.2(b) (5) describes several inappropriate ways of giving discounts or reduced prices. For example, the State will investigate a situation where a laboratory is renting space from a physician's group for operation of a collecting station or for any other purpose. Rental may be for no more than fair market value of the rental space and the rental amount may not be affected by testing ordering volume or value. Investigation for possible criminal offenses, however, may result from these relationships pursuant to 42 USC 1320a-7b.

Similarly, activities which are prohibited include the placement of phlebotomists in a health purveyor's office, the provision of secretarial and clerical personnel to ordering providers or the acceptance of such personnel, the provision of supplies and equipment such as fax machines, personal computers, medical waste disposal services, etc.

- **False claims, false statements and conspiracy.**

All of the following are examples of conduct, which constitutes fraud and abuse:

Physician Manual Policy Guidelines

- Submitting, or causing to be submitted, a claim to the Program for unfurnished medical care, services or supplies;
- Submitting, or causing to be submitted, a claim to the Program for unnecessary medical care, services or supplies;
- Making, or causing to be made, any false statement or misrepresentation of material facts in submitting a claim to the Program;
- Making any agreement to defraud the Program by obtaining or aiding anyone to obtain payment of any false claim to the Program.

Section VI - 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.

The written order must include, but is not limited to, the following elements of information:

Recipient Information

- Name
- Medicaid I.D. Number
- Year of Birth
- Sex

Ordering Provider Information

- *MMIS I.D. Number
(if not MMIS enrolled use
license number)
- Name
- Address
- Telephone Number
- Services Requested
- Date of Request
- Ordering Provider's Original
Signature

Recipient Information

When applicable:

- Diagnosis
- Medicare H.I.C. Number or
Other Insurance Information
- Indication if Service Related to:
Accident
Crime
Family Planning
Physically Handicapped
Children's Program
Abortion or Sterilization
- Prior Approval Number

Note: When a physician assistant orders services, the order must contain the supervising physician's Medicaid Provider I.D. Number (or license number if not Medicaid enrolled).

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
- 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-9-CM code or a narrative description. Use of the ICD-9-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 long-term 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 triplicate 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 5 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.

Drug Utilization Review Programs

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

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

The Federal legislation requiring States to implement DUR programs also requires States to establish DUR Boards whose function is to play a major role in each State's

DUR program. The Department of Social Services established a DUR Board comprised of health care professionals with recognized knowledge and expertise. The Board consists of five physicians, five pharmacists, two persons with expertise in drug utilization review and one designee of the Commissioner of Health. The Board is administered and maintained by the Department of Health.

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

RetroDUR

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

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

ProDUR

The mandated Prospective Drug Utilization Review Program (ProDUR) through the Medicaid Eligibility Verification System (MEVS), is a point-of-sale system which allows pharmacists to perform on-line, real-time eligibility verifications, electronic claims capture (ECC) and offers protection to Medicaid recipients in the form of point-of-sale prevention against drug-induced illnesses.

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

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 recipient 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.

Hospital-Based Ambulatory Surgery Program

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." Hospital-based ambulatory surgery patients will typically utilize the operating room, recovery room, anesthesia services and other related ancillary services in the course of their treatment, and will come to or be brought to the hospital for purposes of a surgical procedure.

Outpatient surgical procedures typically performed in a doctor's office or ambulatory treatment room setting shall not be considered hospital-based ambulatory surgery services."

When an ambulatory patient requires surgery in a hospital or diagnostic and treatment center operating room, payment may be made to the facility at the appropriate ordered ambulatory operating room fee. The operating physician *may not* bill Medicaid directly for these services if he/she is employed by the hospital or diagnostic and treatment center and if any part of his/her salary is for direct patient care. In such cases, payment to the facility for use of the operating room covers the physician's services.

If the physician is not employed by the hospital, he/she may bill independently.

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

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

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

- The provider practices in the “common medical marketing area” of the recipient’s home social services district as defined by the DOH;
- An emergency requires that immediate care be provided to a recipient who is **temporarily** out-of-state;
- Care is provided to a patient who is an approved out-of-state placement. Such placements include patients approved, for example, for nursing home or foster care services in another state: or,
- The patient is Medicare approved.

Any out-of-state medical service that does not fit within the above criteria requires Prior Approval.

A request for Prior Approval for out-of-state medical services must include a letter of medical necessity from the in-state referring physician together with documentation that the requested out-of-state medical care and services are not available in New York State.

Approval will be based on the Department’s determination that care should be provided out-of-state.

For a mentally disabled recipient, approval is also subject to the concurrence of the New York State Office of Mental Health or the New York State Office of Mental Retardation/Developmental Disabilities.

Requests for out-of-state Prior Approval should be directed to:

**New York State Department of Health
Bureau of Medical Review and Payment
Medical Prior Approval Unit
150 Broadway, Suite 6E
Albany, New York 12204-2736**

Please be advised that only providers in the United States (including the U.S. Virgin Islands, Puerto Rico and Guam) and Canada are eligible for enrollment in the New York State Medicaid program. Providers not currently enrolled must complete an enrollment application **and** be approved to participate in the program. Payment to enrolled/approved providers is governed by Title 18NYCRR, Part 527.1. Claims must be submitted to the State's fiscal agent, Computer Sciences Corporation. Facility claims must be submitted electronically; practitioner claims may be submitted either electronically or via paper.

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.

The practitioner must individually order laboratory tests ordered from an independent laboratory. No payment will be made to independent clinical laboratories for laboratory tests ordered in a panel/profile format or for tests ordered in any other type of grouping combination of tests. Medicaid payment to the independent clinical laboratory will be disallowed for individually ordered tests which are ordered on a form which also contains an order for a grouping or combination of tests.

For purposes of this ordering requirement, a panel defined by a single procedure code in the *Laboratory Provider Manual* is considered to be an individual test. No payment will be made to a clinical laboratory for tests ordered as groupings or combinations of tests.

Certain specific tests may continue to 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

In addition, 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
- Glucose
- BUN (Urea Nitrogen)
- Sodium
- Potassium
- Chloride
- Carbon Dioxide (CO₂)
- SMA-12
- Glucose
- BUN
- Calcium
- Phosphorus
- Protein
- Albumin
- Uric Acid
- Cholesterol
- SGOT
- Alkaline Phosphates
- Bilirubin
- Creatinine

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

- **Basic metabolic panel:** this panel must include the following: Calcium, Carbon dioxide, Chloride, Creatinine, Glucose, Potassium, Sodium, Urea nitrogen.
- **Electrolyte panel:** this panel must include the following: Carbon dioxide, Chloride, Potassium, Sodium.
- **Comprehensive metabolic panel:** this panel must include the following: Albumin, Bilirubin total, Calcium, Carbon dioxide, Chloride, Creatinine, Glucose, Phosphatase alkaline, Potassium, Protein total, Sodium, Transferase, alanine amino, Transferase, aspartate amino, Urea nitrogen.
- **Lipid panel:** this panel must include the following: Cholesterol, serum, total, Lipoprotein, direct measurement, high-density cholesterol, triglycerides.
- **Renal function panel:** this panel must include the following: Albumin, Calcium, Carbon dioxide, Chloride, Creatinine, Glucose, Phosphorus, inorganic, Potassium, Sodium, Urea nitrogen.

- **Hepatic function panel:** this panel must include the following: Albumin Bilirubin, total, Bilirubin, direct, Phosphatase, alkaline, Protein, total, Transferase, alanine amino, Transferase, aspartate amino.

With respect to the automated chemistry tests (SMA) noted above, these tests grouping should not be ordered for every patient routinely. 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.

A physician who feels it is necessary to order both an SMA-6 and an SMA-12, for the same patient on the same date of service would be expected to justify the medical necessity for each of the individual components of both the SMA-6 and the SMA-12 in the patient's medical record.

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.

Rules for Ordering Medicaid Transportation

The Medicaid program must ensure that recipients have access to medical care and services. One aspect of this policy is the assurance that recipients have access to transportation resources. Access to transportation resources includes the use of personal vehicles, public transportation, transportation assistance provided by friends or relative and any other method by which recipients conduct their activities of daily living which include shopping, entertainment and attendance at places of worship.

The Medicaid program can and should provide transportation to recipients who do not have access to transportation services as described above.

Physicians and medical practitioners are responsible for ordering medical transportation for New York City Medicaid recipients. Supporting documentation must be maintained for every order by completing the MAP (Medical Assistance Program) form 2015. A basic consideration when ordering transportation for any Medicaid recipient should be the recipient's current level of mobility and functional independence. It is generally expected that, due to the extensive network of mass transportation in New York City, New York City Medicaid recipients should use mass transportation to travel to and from medical appointments unless a specific condition contraindicates such use.

However, Medicaid will pay for the recipient's use of New York City Transit (NYCT) bus or subway at the amount charged to all users of the transit system when:

- The recipients travel distance exceeds ten city blocks one way by the most direct route, or
- The recipient is within the ten-block radius of the treatment location but is unable to reach treatment without use of a bus or subway due to an existing medical condition or inclement weather.

As indicated by the chart below, livery, ambulette and non-emergency ambulance transportation of Medicaid recipients is to be ordered only by specific medical practitioners:

Livery and Ambulette

Physician
Physician's Assistant
Nurse Practitioner
Optometrist
Dentist

Ambulance

Physician
Physician's Assistant
Nurse Practitioner

Clinics, hospitals, and other medical facilities are allowed to order transportation on behalf of the above-named providers; however, evidence of the need for such transportation should be documented by one of the above practitioners (in New York City, ordering practitioner(s) must complete the MAP 2015 form; to obtain the form, telephone 212-630-1513).

The Medicaid Program may pay the costs incurred by Medicaid recipients only when traveling to and from medical care and services covered under the Medicaid program and only when the recipient has no other way to get to the medical care. The medical practitioner requesting livery or taxi, ambulette or ambulance, is responsible for ordering the appropriate modes of transportation for the Medicaid recipient. A provider should not order these services, if the recipient can get to medical care on his/her own.

Upstate medical practitioners may order transportation or be asked to provide supporting documentation for recipients who request transportation from their fiscally responsible local departments of social services.