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 | INFORMATIONAL LETTER |
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TRANSMITTAL: 91 INF-46

TO: Commissioners of
 Social Services

DIVISION: Medical
 Assistance

DATE: August 30, 1991

SUBJECT: Provider Prior Approval/Satisfaction of Pre-Claiming
 Conditions

SUGGESTED

DISTRIBUTION: Third Party Resources Staff
 Income Maintenance Staff
 Medical Assistance Staff

CONTACT PERSON: Fred Perkins, Third Party Resources
 1-800 342-3715, extension 3-0149

ATTACHMENTS: 18 NYCRR 540.6(e)(6) (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		540.6(e)(6)	20(3)(d) 34(3)(F) 363-a		

The purpose of this release is to advise social services districts that Section 540.6(e) of the NYCRR is amended by adding a new paragraph (6). The amended regulation becomes effective on August 21, 1991. It is presented in its entirety on Attachment I.

The new paragraph (6) reinforces the existing billing practices that Medicaid providers must follow when providing services to or making referrals for recipients who are covered by third party health insurance.

Specifically, when the third party carrier indicates on the recipient's health insurance card that prior approval for certain services must be obtained by the provider prior to carrier reimbursement, the provider must make a reasonable attempt to obtain the prior approval for the service or ensure that the recipient obtains the prior approval before submitting any claims to Medicaid.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

ATTACHMENT I

Section 540.6(e) is amended by adding a new paragraph (6) to read as follows:

(6) A provider of medical assistance must review and examine information relating to available health insurance and other potential third-party resources for each medical assistance recipient to determine if a health insurance identification card or any other information indicates that prior or other approval is required for non-emergency, post-emergency, non maternity, hospital, physician or other medical care, services or supplies. If approval is required as a condition of payment or reimbursement by an insurance carrier or other liable third party, the provider must obtain for the recipient, or ensure that the recipient has obtained, any necessary approval prior to submitting any claims for reimbursement from the medical assistance program. The provider must comply with all Medicare or other third party billing requirements and must accept assignment of the recipient's right to receive payment or must acquire any other rights of the recipient necessary to ensure that no reimbursement is made by the medical assistance program when the costs of medical care, services or supplies could be borne by a liable third party. If a provider fails to comply with these conditions, any reimbursement received from the medical assistance program in violation of the provisions of this paragraph must be repaid to the medical assistance program by such provider. No repayment will be required if the provider can produce acceptable documentation to the department that the provider reasonably attempted to ascertain and satisfy any conditions of approval or other claiming requirements of liable third party payors in the same manner and to the same extent as the provider would for individuals for whom reimbursement is not available under the medical assistance program, as described in paragraphs (1) through (5) of this subdivision.