NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner

(518) 474-9475

LOCAL COMMISSIONERS MEMORANDUM

DSS-4037EL (Rev. 9/89)

Transmittal No: 92 LCM-157

Date: October 14, 1992

Division: Health and Long Term Care

TO: **Local District Commissioners**

SUBJECT: Chapter 41 of the Laws of 1992: Changes to the Medicaid Program

ATTACHMENTS:
1. Dear Medicaid Recipient letter (on-line)
2. Dear Medicaid Home Relief Recipient letter (on-line)
3. Medicaid Co-Payment and Podiatry Fact Sheet(on-line)
4. Draft Article For Deficit Reduction Plan (on-line)
5. Draft Pharmacy Provider Letter (on-line)

NOTE: Spanish versions of above to be sent under separate cover.

This Local Commissioners Memorandum (LCM) provides districts with further details pertaining to the Department's implementation of Medicaid Program changes mandated by Chapter 41 of the Laws of 1992. These changes were previously described in Local Commissioners Memorandum 92 LCM-73.

I. Co-Payments

A court-ordered temporary restraining order (TRO) was issued in late May delaying implementation of the recipient co-payment requirements pursuant to Chapter 41 of the Laws of 1992 and as described in the above referenced LCM. The court has now issued an order that permits the Department to proceed with implementation of recipient co-payment as originally proposed (please refer to 92 LCM-73 for a detailed description of the recipient co-payment requirements including the services subject to co-payment and applicable exemptions). Note that, due to ongoing litigation regarding co-payments, there may be some changes in the Department's implementation plans. If any changes occur you will be notified by October 23, 1992.

Effective December 1, 1992, certain Medicaid recipients may be asked to contribute to the cost of some medical services/items. Notices are being sent out to all providers advising them of full implementation of recipient co-payment. The attached Dear Medicaid Recipient letters explaining the new program requirements will be mailed in early November, 1992 by the Department to all recipients determined eligible as of October 23, 1992 who have an effective eligibility date of November 1, 1992.

Please refer to 92 LCM-73 for details of co-payment requirements. The following revisions and clarification to policy have been made to the co-payment requirements since the release of 92 LCM-73:

1. Residents of community based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities are now exempt from co-payments;

2. Home Health Services are now exempt from co-payment;

3. Pregnant women are exempted from co-payment through the second month after the end of the pregnancy;

4. Drugs used in the treatment of tuberculosis are exempt from co-payment;

5. The list of exempt psychotropic drugs has been expanded.

There is a maximum recipient co-payment of $50 for drugs dispensed between January 1, 1993 and March 31, 1993. Recipients have been instructed that, if they think they might need more than 25 prescriptions in the three month period above, they should ask their pharmacist to help them keep a record of all prescriptions subject to co-payments. They will then know when the drug co-payments no longer apply. Pharmacists have been instructed to provide recipients with the ordered drugs and not to charge a co-payment under such circumstances. In addition, starting on April 1, 1993 there is a $100 per year maximum per recipient on **ALL** co-payments. Beginning on this date the Department will record all co-payments incurred by recipients and will inform providers via EMEVS when a recipient has reached the $100 annual maximum.

Effective immediately, local districts must include the attached Medicaid Co-payment and Podiatry Fact Sheet with all State-mandated acceptance notices to PA or MA-only recipients 21 years of age or older (one fact sheet per case). The Fact Sheet should also be given at recertification to clients who are turning age 21 since eligibility was last established.

II. Podiatry

Another court-ordered TRO was issued in late June prohibiting the Department from implementing the other provisions of Chapter 41 of the Laws of 1992 relating to Medicaid including elimination of many direct payments to podiatrists for dates of service on and after July 1, 1992. We now have been advised by the State's Attorney General's Office that the court order **is not** applicable to the reduction in podiatry services. Therefore, effective December 1, 1992, the Department will again be implementing

program revisions discontinuing many direct payments to podiatrists. New York State Medicaid **will** continue direct payments to enrolled podiatrists for medically necessary foot care only under the following circumstances:

1. Services to children (under age 21) upon the written referral of a physician, physician's assistant, nurse practitioner, nurse midwife, or clinic.

2. The Medicare coinsurance and deductible will continue to be paid for Medicaid recipients considered to be Qualified Medicare Beneficiaries (QMB's). A QMB is an individual eligible for Medicare who meets federally established income and resource levels. At the present time, podiatrists can consider any Medicaid recipient who has Medicare coverage to meet this criteria.

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 certified clinics which include podiatry services in the rate established for medical care for Medicaid recipients will continue to receive payments for podiatry services through their rates. Podiatrists salaried by these facilities will not be affected by the legislative change in covered services. Additionally, Medicaid will continue to pay for medically necessary items and supplies (e.g., prescription drugs) for all recipients when ordered by a private practicing podiatrist.

III. Other Changes

The TRO issued in late June has prohibited the Department from implementing the provisions of Chapter 41 of the Laws of 1992 revising the Medicaid benefit package for FNP recipients, limitation on impatient services for federally nonparticipating (FNP) recipients, and changes to the Utilization Threshold Program. This TRO has also prevented the Department from full implementation of the Medical Care Coordinator Program (MCCP). The TRO remains in effect. Local districts will be advised of the final decision by the court on the motion for a preliminary injunction. Specifically affected are:

1. Changes in Benefits Available to FNP Recipients Aged Twenty-One Through Sixty-Four Years Who Have Not Been Certified as Blind or Disabled for Medicaid Purposes;
2. 32 Day Hospital Limitation for FNP Recipients Aged 21 Through 64 Who Have Not Been Certified as Blind or Disabled for Medicaid Purposes; and
3. Changes to the Utilization Threshold Program.

An Administrative Directive will follow describing required action.

Further questions on the above Medicaid changes may be directed to Richard Nussbaum, 1-800-342-3715, extension 3-0912; user-ID DMA041.

Gregory Kaladjian
Executive Deputy Commissioner

Dear Medicaid Recipient:

In May, 1992, we sent a letter to all Medical Assistance ("Medicaid") recipients informing them of changes to the Medicaid Program because of a new law. If you were eligible for Medicaid in May, you should have received this letter. You were told that starting on June 1st, Medicaid providers would ask you to pay part of the cost of your medical care. This is commonly called a co-payment. You also were told that Medicaid would no longer pay for podiatry services, except under certain conditions. These changes to the Medicaid Program were delayed because of a court order, but we are now allowed to make these changes.

IT IS IMPORTANT THAT YOU READ THIS LETTER TO UNDERSTAND THESE CHANGES AND THAT YOU SAVE THIS LETTER FOR FUTURE USE

CO-PAYMENT

Starting on December 1, 1992, if you are 21 years of age or older, your health care provider will be allowed to ask you for the co-payment.

IF YOU ARE UNABLE TO PAY THE REQUESTED CO-PAYMENT, TELL YOUR HEALTH CARE PROVIDER WHEN THE PROVIDER ASKS YOU FOR PAYMENT. YOU CAN STILL GET THE SERVICES YOU NEED FROM YOUR PROVIDER. THE PROVIDER CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS BECAUSE YOU TELL THE PROVIDER THAT YOU ARE UNABLE TO PAY THE CO-PAYMENT.

There is a toll free telephone number that you can use to report providers who refuse to give you care and tell you that it is because you are unable to pay the co-payment. The number is **1-800-541-2831** and can be called between 9:00 a.m. and 5:00 p.m. Monday through Friday.

There are a number of EXEMPTIONS from co-payments. Please read this entire letter to see if you or the services that you need are exempt from the co-payment requirement.

Your health care provider will be allowed to ask for co-payment only for:

1. **INPATIENT HOSPITAL CARE** - The co-payment for each hospital stay (if you have to stay one or more nights) is $25. You may be asked for this co-payment when you leave the hospital.

2. **EMERGENCY ROOM VISITS** - The co-payment for each non-emergency or non-urgent visit to an emergency room is $3.00. **If you get emergency or urgent care in the emergency room, you will not have to pay a co-payment.** The emergency room will decide whether you are getting emergency or urgent care.

3. **CLINIC VISITS** - The co-payment for each visit to a clinic is $3.00. Visits to clinics for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not have a co-payment.

   There is no co-payment for services by private practicing physicians. If you do not know if your doctor is with a clinic or is a private practicing physician, you should ask your doctor.

4. **PRESCRIPTION DRUGS** - The co-payment for each new prescription and each refill for a brand-name drug is $2.00. The co-payment for each new prescription and each refill for a generic drug is $.50. There is no co-payment for certain drugs to treat mental illness or tuberculosis. Your pharmacist can tell you if there is a co-payment for the drug you need.

5. **NONPRESCRIPTION DRUGS** - The co-payment for each new order and each refill for a nonprescription (over-the-counter) drug is $.50.

6. **SICKROOM SUPPLIES** - The co-payment for each new order and each refill for a sickroom supply is $1.00. Sickroom supplies include ostomy bags, heating pads, bandages, gloves, vaporizers, etc.

7. **LABORATORY SERVICES** - The co-payment for each laboratory procedure billed by a laboratory to Medicaid is $.50.

8. **X-RAYS** - The co-payment for each x-ray you get is $1.00. If the x-ray is taken by your doctor in his/her office, there is no co-payment.

NOTE: There is no co-payment for Home Health Services.

EXEMPTIONS: YOU DO NOT HAVE TO PAY THE CO-PAYMENT IF:

1. You are unable to pay and you tell your provider that you are unable to pay.

2. You are younger than 21 years of age.

3. You are pregnant. If you are pregnant, have your doctor write a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.

4. Your medical care is being provided by a managed care provider or a health maintenance organization (HMO). Your local social services office can tell you if you belong to a managed care program or HMO.

5. You are a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or a Nursing Facility.

6. You are a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental

Retardation and Developmental Disabilities. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payments.

7. You are getting services for family planning (birth control or fertility). This includes family planning drugs or supplies such as birth control pills or condoms.

8. You are getting care or services for an emergency. This is care given to you to treat a severe life-threatening or potentially disabling condition that needs immediate care.

Between January 1, 1993 and March 31, 1993, there will be a $50 maximum total co-payment for drugs. If you think you might need more than 25 prescriptions in the three month period of January 1, 1993 through March 31, 1993, you should ask your pharmacist to help you keep a record of all prescriptions subject to co-payment. You will then know when the drug co-payment no longer applies to you and you will no longer be asked for additional co-payments for drugs.

Starting on April 1, 1993, there is a $100 per year maximum per recipient on ALL co-payments. The New York State Department of Social Services will record all co-payments that you incur, and inform your provider by computer when you have met the $100 maximum. The provider will be told not to charge you any more co-payments for that year.

Save your co-payment receipts if you are eligible for Medicaid by spending part of your income towards medical care. The co-payments you pay or incur will count towards your spend down for the following month.

REMINDER - PROVIDERS CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS IF YOU CANNOT PAY THE CO-PAYMENT AND TELL THIS TO THE PROVIDER.

PODIATRY

Starting on December 1, 1992, Medicaid coverage of podiatry services by private practicing podiatrists will change.

1. **For recipients under 21 years old**, Medicaid will pay for your care if a physician, nurse practitioner or nurse midwife orders the care in writing.

2. **For recipients over 21 years of age, and who have Medicare coverage**, Medicaid will continue to pay for care provided by a podiatrist participating in the Medicaid Program.

3. **For recipients over 21 years of age, who do not have Medicare coverage**, Medicaid will not pay directly for care provided by private practicing podiatrists. Medically necessary foot care may be provided by some clinics and physicians who offer the care.

NOTE: Medicaid will pay for medically necessary items and supplies such as prescription drugs for all recipients when ordered by a private practicing podiatrist.

FAIR HEARINGS: See the attachment for your fair hearing rights. You have a right to a fair hearing if you think we made a mistake about the date of your birth and you are not age 21 or older or we made a mistake about whether you are in a managed care program or HMO. The hearing officer at the hearing may decide that you did not have the right to a hearing if you are only complaining about the change in State law.

Sincerely,

Gregory Kaladjian
Executive Deputy Commissioner

MA Chapter 41 Notice (Copayment and Podiatry)

RIGHT TO A CONFERENCE: You may have a conference to review this action. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling your worker or by sending a written request to your local social services department. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid-continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

FAIR HEARING REQUEST: These changes in your Medical Assistance coverage are based on a change in State law. You have the right to have a fair hearing if you think we made a mistake about your date of birth or whether you are in a managed care program or HMO, but not just because you think the new law is unfair. The hearing officer at the hearing may decide that you do not have a right to a hearing or a continuation of Medical Assistance, if the only issue at the hearing is the change in State law. You may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in:	New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550
If you live in:	Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868.
If you live in:	Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868.
If you live in:	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868.
If you live in:	Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

OR

(2) Writing: By sending a copy of both pages of this notice, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. PLEASE KEEP A COPY FOR YOURSELF.

I want a fair hearing. The Agency's action is wrong because:

Signature of Client_____Date_____Case #_____

Address: _____

Telephone # _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, and medical verification that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box , the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling your worker.

ACCESS TO RECORDS/ INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call your worker or send a copy of this notice, or send a written request to your local social services department.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case record and/or additional copies of documents, you may call your worker or write to you local social services department.

Dear Medicaid Home Relief Recipient:

In May, 1992, we sent a letter to all Medical Assistance ("Medicaid") recipients informing them of changes to the Medicaid Program because of a new law. If you were eligible for Medicaid in May, you should have received this letter. You were told that starting on June 1st, Medicaid providers would ask you to pay part of the cost of your medical care. This is commonly called a co-payment. You also were told that Medicaid would no longer pay for podiatry services, except under certain conditions. These changes to the Medicaid Program were delayed because of a court order, but we are now allowed to make these changes.

IT IS IMPORTANT THAT YOU READ THIS LETTER TO UNDERSTAND THESE CHANGES AND THAT YOU SAVE THIS LETTER FOR FUTURE USE

CO-PAYMENT

Starting on December 1, 1992, if you are 21 years of age or older, your health care provider will be allowed to ask you for the co-payment.

IF YOU ARE UNABLE TO PAY THE REQUESTED CO-PAYMENT, TELL YOUR HEALTH CARE PROVIDER WHEN THE PROVIDER ASKS YOU FOR PAYMENT. YOU CAN STILL GET THE SERVICES YOU NEED FROM YOUR PROVIDER. THE PROVIDER CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS BECAUSE YOU TELL THE PROVIDER THAT YOU ARE UNABLE TO PAY THE CO-PAYMENT.

There is a toll free telephone number that you can use to report providers who refuse to give you care and tell you that it is because you are unable to pay the co-payment. The number is **1-800-541-2831** and can be called between 9:00 a.m. and 5:00 p.m. Monday through Friday.

There are a number of EXEMPTIONS from co-payments. Please read this entire letter to see if you or the services that you need are exempt from the co-payment requirement.

Your health care provider will be allowed to ask for co-payment only for:

1. **INPATIENT HOSPITAL CARE** - The co-payment for each hospital stay (if you have to stay one or more nights) is $25. You may be asked for this co-payment when you leave the hospital.

2. **EMERGENCY ROOM VISITS** - The co-payment for each non-emergency or non-urgent visit to an emergency room is $3.00. **If you get emergency or urgent care in the emergency room, you will not have to pay a co-payment.** The emergency room will decide whether you are getting emergency or urgent care.

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   There is no co-payment for services by private practicing physicians. If you do not know if your doctor is with a clinic or is a private practicing physician, you should ask your doctor.

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NOTE: There is no co-payment for Home Health Services.

EXEMPTIONS: YOU DO NOT HAVE TO PAY THE CO-PAYMENT IF:

1. You are unable to pay and you tell your provider that you are unable to pay.

2. You are younger than 21 years of age.

3. You are pregnant. If you are pregnant, have your doctor write a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.

4. Your medical care is being provided by a managed care provider or a health maintenance organization (HMO). Your local social services office can tell you if you belong to a managed care program or HMO.

5. You are a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or a Nursing Facility.

6. You are a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental

Retardation and Developmental Disabilities. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payments.

7. You are getting services for family planning (birth control or fertility). This includes family planning drugs or supplies such as birth control pills or condoms.

8. You are getting care or services for an emergency. This is care given to you to treat a severe life-threatening or potentially disabling condition that needs immediate care.

Between January 1, 1993 and March 31, 1993, there will be a $50 maximum total co-payment for drugs. If you think you might need more than 25 prescriptions in the three month period of January 1, 1993 through March 31, 1993, you should ask your pharmacist to help you keep a record of all prescriptions subject to co-payment. You will then know when the drug co-payment no longer applies to you and you will no longer be asked for additional co-payments for drugs.

Starting on April 1, 1993, there is a $100 per year maximum per recipient on ALL co-payments. The New York State Department of Social Services will record all co-payments that you incur, and inform your provider by computer when you have met the $100 maximum. The provider will be told not to charge you any more co-payments for that year.

Save your co-payment receipts if you are eligible for Medicaid by spending part of your income towards medical care. The co-payments you pay or incur will count towards your spend down for the following month.

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ADDITIONAL NOTICE FOR HOME RELIEF RECIPIENTS

You or a member of your household is listed as a Home Relief recipient for Medicaid purposes. There may soon be limits on the Medicaid services available to Home Relief recipients. You may be able to keep your full Medicaid benefits if any of the following is true for you or a member of your household:

1. You are caring for a child who is under age 21, who is your relative and who lives with you.

2. You believe you are blind or disabled.

3. You are under 21 years of age.

4. You are pregnant or were pregnant during the past two months.

5. You have applied for SSI or Social Security Disability but have not yet heard whether your application has been approved, or you are appealing a denial of your application.

If any of these five things is true please go to your local social services office and ask them to review whether you can get Medicaid without the Home Relief limits. In New York City go to your Income Support Center (Welfare Center); if you are not receiving Welfare, go to your Medicaid Office and ask them.

If we change your category, this will not stop or reduce your cash assistance or food stamps.

Sincerely,

Gregory Kaladjian
Executive Deputy Commissioner

MEDICAID CO-PAYMENT AND PODIATRY FACT SHEET

CO-PAYMENT

Medicaid recipients age 21 or older may be asked to pay part of the costs of some medical care/items. This is called co-payment. Your health care provider will be allowed to ask you for the co-payment.

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3. You are pregnant. If you are pregnant, have your doctor write a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.

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5. You are a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or a Nursing Facility.

6. You are a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payments.

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8. You are getting care or services for an emergency. This is care given to you to treat a severe life-threatening or potentially disabling condition that needs immediate care.

Between January 1, 1993 and March 31, 1993, there will be a $50 maximum total co-payment for drugs. If you think you might need more than 25 prescriptions in the three month period of January 1, 1993 through March 31, 1993, you should ask your pharmacist to help you keep a record of all prescriptions subject to co-payment. You will then know when the drug co-payment no longer applies to you and you will no longer be asked for additional co-payments for drugs.

Starting on April 1, 1993, there is a $100 per year maximum per recipient on ALL co-payments. The New York State Department of Social Services will record all co-payments that you incur, and inform your provider by computer when you have met the $100 maximum. The provider will be told not to charge you any more co-payments for that year.

Save your co-payment receipts if you are eligible for Medicaid by spending part of your income towards medical care. The co-payments you pay or incur will count towards your spend down for the following month.

REMINDER - PROVIDERS CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS IF YOU CANNOT PAY THE CO-PAYMENT AND TELL THIS TO THE PROVIDER.

PODIATRY

Starting on December 1, 1992, Medicaid coverage of podiatry services by private practicing podiatrists will change.

1. **For recipients under 21 years old,** Medicaid will pay for your care if a physician, nurse practitioner or nurse midwife orders the care in writing.

2. **For recipients over 21 years of age, and who have Medicare coverage,** Medicaid will continue to pay for care provided by a podiatrist participating in the Medicaid Program.

3. **For recipients over 21 years of age, who do not have Medicare coverage,** Medicaid will not pay directly for care provided by private practicing podiatrists. Medically necessary foot care may be provided by some clinics and physicians who offer the care.

NOTE: Medicaid will pay for medically necessary items and supplies such as prescription drugs for all recipients when ordered by a private practicing podiatrist.

FAIR HEARINGS: See the attachment for your fair hearing rights. You have a right to a fair hearing if you think we made a mistake about the date of your birth and you are not age 21 or older or we made a mistake about whether you are in a managed care program or HMO. The hearing officer at the hearing may decide that you did not have the right to a hearing if you are only complaining about the change in State law.

ELIMINATION OF FEE-FOR-SERVICE PODIATRY

Recently enacted changes to Social Services Law (Chapter 41 of the Laws of 1992) significantly altered the scope of medical services available to certain Medicaid recipients. Included in the changes were elimination of many direct payments to podiatrists for dates of service on and after July 1, 1992. However, as was described in a July 14, 1992 letter you received from this Department, implementation of many of the Medicaid cost containment initiatives, including those affecting podiatry services, were delayed as a result of a court issued temporary restraining order (TRO). While the TRO remains in effect for many of the Medicaid Program revisions, we have now been advised by the State's Attorney General's Office that the court order **is not** applicable to the reduction in podiatry services. Therefore, for dates of service effective December 1, 1992, the Department will again be implementing program revisions discontinuing many direct payments to podiatrists. New York State Medicaid **will** continue direct payments to enrolled podiatrists for medically necessary foot care only under the following circumstances:

- Payment for services to children (under age 21) upon the written referral of a physician, physician's assistant, nurse practitioner, nurse midwife, or clinic will be made. To insure payment, the referring practitioner's MMIS identification number, or license number with license type code, must be entered on each podiatrist's claim submitted to Medicaid for payment. The written referral must be maintained in the patient's medical records file and is considered acceptable for six months from the date written.

- The Medicare coinsurance and deductible will continue to be paid for Medicaid recipients considered to be Qualified Medicare Beneficiaries (QMB's). A QMB is an individual eligible for Medicare who meets federally established income and resource levels. At the present time, podiatrists can consider any Medicaid recipient who has Medicare coverage to meet this criteria.

Nursing facilities, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's), and Article 28 or Article 31 certified clinics which include podiatry services in the rate established for medical care for Medicaid recipients will continue to receive payments for podiatry services through their rates. Podiatrists salaried by these facilities will not be affected by the legislative change in covered services.

DRAFT
ARTICLE FOR DEFICIT REDUCTION PLAN (10/5/92 VERSION)
CO-PAYMENTS

A recent decision by the Federal court authorizes the Department to proceed with implementation of co-payments. Implementation of co-payments had been delayed as a result of a court-ordered temporary restraining order. The temporary restraining order is no longer valid. Therefore, for dates of service effective December 1, 1992, co-payments will be in effect. Following are the major changes from the May, 1992 Medicaid Update article which described co-payments:

1- Residents of community based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities are now exempt from co-payments;

2- Home Health Services are now exempt from co-payment;

3- Pregnant women are exempted from co-payment through the second month after the end of the pregnancy;

4- Drugs used in the treatment of tuberculosis are exempt from co-payment;

5- The list of exempt psychiatric drugs has been expanded.

CO-PAYMENT SPECIFICATIONS

PROVIDERS' OBLIGATIONS TO PROVIDE SERVICES (RECIPIENT'S INABILITY TO PAY):

The co-payment legislation includes the provision that the provider may not deny services to eligible recipients based on the recipient's inability to pay the co-payment amount. Providers may not refuse to provide services to otherwise eligible Medicaid recipients who state that they do not have the co-payment or are unable to pay. Not providing services is an unacceptable practice. Under these circumstances, a provider will be required to accept the reduced Medicaid payment as payment in full.

INPATIENT HOSPITAL CO-PAYMENT:

Each inpatient hospital stay billed to the Medicaid Management Information System (MMIS) will have a $25 co-payment deducted from the final payment amount calculated as due from Medicaid. If a Medicaid recipient is transferred to another inpatient facility for specialty or continuing care, a co-payment will be deducted from the payment made to the facility which discharges the recipient from inpatient care to a non-inpatient level of care. If a recipient is discharged to return home and subsequently re-enters the same inpatient facility, co-payments will be deducted for both inpatient stays upon billing at discharge. The co-payment applies to all hospitals certified under Article 28 of Public Health Law. Hospitals with dual certification and hospitals located outside of New York State will be subject to the co-payment provisions for all inpatient care rendered to Medicaid recipients.

OUTPATIENT HOSPITAL AND EMERGENCY ROOM CO-PAYMENT:

Each outpatient hospital visit billed to the Medicaid Management Information System (MMIS) will have a $3.00 co-payment deducted from the final payment amount calculated as due from Medicaid. Visits to hospital emergency rooms for non-emergency or non-urgent medical care will have a $3.00 co-payment deducted from the final payment amount calculated as due from Medicaid.

DIAGNOSTIC AND TREATMENT CENTER (FREE-STANDING CLINICS) CO-PAYMENT:

Each clinic visit billed to the Medicaid Management Information System (MMIS) will have a $3.00 co-payment deducted from the final payment amount calculated as due from Medicaid.

ORDERED AMBULATORY CO-PAYMENT:

Each radiology procedure code in the range 70000 through 79999 including procedures billed with modifiers will have a $1.00 co-payment deducted from the final payment amount calculated as due from Medicaid. Each laboratory procedure billed to the Medicaid Management Information System (MMIS) will have a $.50 co-payment deducted from the final payment amount calculated as due from Medicaid. (Co-payments do not apply to laboratory procedures billed by practitioners for patients in their offices when these practitioners are not licensed as laboratories or to radiology procedures billed by practitioners.)

MEDICAL/SURGICAL SUPPLIER, HEARING AID DISPENSERS AND PHARMACY CO-PAYMENT:

The co-payment amount is $1.00 for each order for a sickroom supply dispensed. Sickroom supplies are identified in sections 4.3 and 4.4 of the MMIS Pharmacy Provider Manual and in sections 4.1, and 4.3 of the MMIS DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual. Hearing aid dispensers should note that the co-payment applies to hearing aid batteries because they are considered sickroom supplies. The co-payment amount for enteral and parenteral formulae/supplies is $1.00 per order. Enteral and parenteral formulae/supplies are identified in section 4.2 of the MMIS Pharmacy Provider Manual and the MMIS DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual. The co-payment amount is $2.00 for each brand name (single source or innovator multiple source) prescription drug dispensed, $.50 for each generic prescription drug dispensed and $.50 for each nonprescription (OTC) drug dispensed.

CLINICAL LABORATORY CO-PAYMENT:

Each laboratory procedure billed to the Medicaid Management Information System (MMIS) will have a $.50 co-payment deducted from the final payment amount calculated as due from Medicaid. (Co-payments do not apply to laboratory procedures billed by practitioners for patients in their offices when these practitioners are not licensed as laboratories.)

EXEMPTIONS FROM CO-PAYMENT - ALL PROVIDERS:

Important Note: There are no special co-payment exemptions for recipients age 65 and older, restricted recipients and recipients in the Medical Care Coordinator Program. The only co-payment exemptions are described in the following section.

1. EMERGENCY SERVICES:
   Emergency services which are provided after the sudden onset of a medical condition, which manifests itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, are exempt from co-payment.

   - MMIS claiming instructions:

   o Outpatient hospitals, clinics, and ordered ambulatory providers must enter a "Y" for yes in the Emergency Related field on the Medicaid claim to identify the service as an emergency when submitting the claim to MMIS for payment.
   o Pharmacies and medical/surgical suppliers must enter the code "L" in the SA Excp Code field to identify an emergency when submitting the claim to MMIS for payment.
   o Inpatient hospitals must enter the emergency code in the Type (of admission) field to identify an emergency when submitting the claim to MMIS for payment.

2. FAMILY PLANNING SERVICES AND ITEMS:
   Medical services, drugs and supplies provided for family planning purposes are exempt from co-payment.

   - MMIS claiming instructions:

   o Inpatient hospitals must enter a "Y" for yes in the family planning area in the Special Program field to identify a family planning claim when family planning is the primary procedure when submitting the claim to MMIS for payment.
   o Outpatient hospitals, clinics, ordered ambulatory and laboratory providers must enter a "Y" for yes in the Family Planning field on the Medicaid claim to identify the service as a family planning service when submitting the claim to MMIS for payment.
   o Pharmacies and medical/surgical suppliers are NOT required to use a special code on the claim to identify family planning claims. Family planning drugs and suplies include products identified in the Provider Manuals under the headings of "Family Planning Products" as well as any prescription drug which is used for family planning purposes.

3. RECIPIENTS UNDER AGE 21:
   Recipients under age 21 are exempt from co-payments. These recipients can be identified by the date of birth of the recipient which is printed on the plastic Common Benefit Identification Card. The date of birth will be compared with the date of service. Providers do not need to enter a special code on Medicaid claims to identify these recipients. It should be noted that refills dispensed after a recipient turns age 21 will require a co-payment.

4. PREGNANT RECIPIENTS:
Pregnant women are exempt from co-payments through the second month after the end of the pregnancy. It is anticipated that a practitioner treating the recipient will be aware that the recipient is pregnant when rendering medical care. Practitioners should note that Medicaid recipients may request a note to show to other providers, such as pharmacies, as evidence of pregnancy. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when a prescription/order source is a Prenatal Care Assistance Program PCAP) or an obstetrician.

-MMIS claiming instructions:

o Inpatient hospitals must enter a "P" for pregnant in the Special Federal Funding Project area in the Special Program field (field 156 on the inpatient claim form) to identify a pregnant recipient when submitting the claim to MMIS for payment. Note: inpatient hospitals may continue to enter "N" or leave the field blank to indicate that no exemption applies.

o Providers other than inpatient hospitals must use the code "Z9" in the Recipient Other Insurance Code field to identify a pregnant recipient when submitting a claim to MMIS for payment.

5. RECIPIENTS ENROLLED IN MANAGED CARE PROGRAMS AND COMPREHENSIVE MEDICAID CASE MANAGEMENT PROGRAMS (CMCM):
Recipients enrolled in managed care programs are exempt from co-payments. Providers do not need to enter a special code on the claim to identify recipients who are in managed care programs. These recipients can be identified by the coverage code message received from the Electronic Medicaid Eligibility Verification System (EMEVS) when checking Medicaid eligibility. Recipients in managed care programs are identified by one of the following messages:

. ELIGIBLE PCP
. ELIGIBLE CAPITATION GUARANTEE
. ELIGIBLE PCP HR
. GUARANTEE HR

Recipients enrolled in a Comprehensive Medicaid Case Management Program (including TASA, OMH/ICM, OMRDD/CMCM, AIDS Case Management, Onondaga County Prenatal Pediatric Case Management and CONNECT) are exempt from co-payments. Providers do not need to enter a special code on the claim to identify recipients who are in these programs. These recipients are identified on EMEVS by the following responses:

"EXCEPTION CODE 35" - Designates an individual who receives CMCM
"EXCEPTION CODE 50" - Designates an individual who is eligible to receive CONNECT-Only Perinatal Family Services
"EXCEPTION CODE 51" - Designates an individual who receives CMCM under the CONNECT Program

6. ICF/DD AND NURSING FACILITY RESIDENTS:
Recipients in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's) or Nursing Facilities are exempt from co-payments. Providers do not need to enter a special code on the claim to identify recipients who are in ICF/DD's or Nursing Facilities. Providers may verify that a recipient is a resident of a nursing facility by checking with the facility. Individuals in ICF/DD's are identified on EMEVS by the following response:

"EXCEPTION CODE 38" - Designates an individual who is a resident of an ICF/DD

7. RESIDENTS OF OMH AND OMRDD CERTIFIED COMMUNITY RESIDENCES:
Recipients who are residents in Community Residences certified by the Office Of Mental Health or the Office of Mental Retardation and Developmental Disabilities are exempt from co-payments. Each month the Community Residence will give recipients a letter which certifies that they live in a community residence and are exempt from co-payment. This letter will serve as verification that a recipient is exempt from co-payment.

-MMIS claiming instructions:

o Inpatient hospitals must enter an "R" in the Special Federal Funding Project area in the Special Program field (field 156) on the inpatient claim form to identify a resident of a Community Residence when submitting a claim to MMIS for payment.

o Providers other than inpatient hospitals must Use the code "Z8" in the Recipient Other Insurance Code field on the claim to identify residents of Community Residences.

8. PHYSICIANS RECEIVING PAYMENTS DIRECTLY FROM MMIS:
Physicians enrolled as private practitioners under category of service 0460 receiving fee-for-service payments from MMIS are NOT subject to co-payment. Physicians will NOT have co-payments for radiology or laboratory services deducted from their claims.

9. HOME HEALTH AND LONG TERM HOME HEALTH CARE:
Home health and long term home health care services are NOT subject to co-payment. Note that this has changed from the previous co-payment notice.

10. CO-PAYMENT MAXIMUM:
Between January 1, 1993 and March 31, 1993 there will be a $50 maximum total co-payment for drugs. It is expected that few recipients may possibly reach the $50 maximum. Recipients who think they might need more than 25 prescriptions in this three month period are instructed to ask their pharmacist to help them keep a record of all prescriptions subject to co-payment. When a recipient has incurred $50 in co-payments refer to the folowing billing instructions to ensure that co-payments will no longer be deducted from your claims: Use the code "Z7" in the Recipient Other Insurance Code field on the claim to identify recipients who have reached the $50 limit.

Starting on April 1, 1993 there is a $100 per year maximum per recipient on **all** co-payments. The Department will record all co-payments incurred by recipients and inform providers via EMEVS when recipients have reached the maximum and no co-payment is due. Further details on how providers may access EMEVS for co-payment information will follow in future communications from the Department.

EXEMPTIONS FROM CO-PAYMENTS - FOR SPECIFIC TYPES OF PROVIDERS:

1. OUTPATIENT HOSPITAL SPECIFIC EXEMPTIONS:

- EMERGENCY ROOM VISITS FOR EMERGENCY OR URGENT CARE:
Visits to hospital emergency rooms for emergency care are exempt from co-payment. However, visits to hospital emergency rooms for non-emergency or non-urgent medical care will have a $3.00 co-payment deducted from the final payment amount calculated as due from Medicaid. (See section on emergency services exemptions for all providers for a definition of emergency services.) Urgent medical care is a situation in which a patient has an acute or active problem which if left untreated might result in an increase in the severity of symptoms, the development of complications, an increase in recovery time and the development of an emergency situation.

- MMIS claiming instructions:
o Providers must indicate "Y" for yes in the Emergency Related field on their Medicaid claim to identify the emergency room visit as an emergency or for urgent care when submitting the claim to MMIS for payment.

2. OUTPATIENT HOSPITAL AND DIAGNOSTIC AND TREATMENT FACILITIES (FREE-STANDING CLINICS) SPECIFIC EXEMPTIONS:

- MMTP, MENTAL HEALTH CLINIC VISITS, MENTAL RETARDATION CLINIC VISITS, ALCOHOL AND SUBSTANCE ABUSE CLINIC VISITS:
Co-payment will not apply to Methadone Maintenance Treatment Program (MMTP) visits, ambulatory mental health services, ambulatory mental retardation services or alcohol and substance abuse clinic visits. The following is the list of specialty and rate codes exempt from co-payments for these types of services:

- Specialty codes EXEMPT from co-payment:

  - 300 - Physical Therapy - Long Term Maintenance
  - 301 - Occupational Therapy - Long Term Maintenance
  - 302 - Speech Therapy - Long Term Maintenance
  - 304 - Medical Rehabilitation - Long Term Maintenance
  - 309 - Medically Supervised Substance Abuse
  - 310 - OMH Adult Clinic (State Operated)
  - 311 - OMH Child Clinic (State Operated)
  - 312 - OMH Continuing Day Treatment (State Operated)
  - 313 - OMH Partial Hospitalization (State Operated)
  - 314 - OMH Intensive Psychiatric Rehabilitative Treatment
  - 315 - OMH Adult Clinic

- 316 - OMH Child Clinic
- 317 - OMH Continuing Day Treatment
- 318 - OMH Partial Hospitalization
- 319 - OMH Intensive Psychiatric Rehabilitative Treatment
- 320 - Clozapine Case Manager
- 922 - Methadone Maintenance Treatment Program
- 945 - Psychiatry, Individual
- 946 - Psychiatry, Group
- 947 - Psychiatry, Half Day Care
- 948 - Psychiatry, Full Day Care
- 949 - Alcoholism Treatment Program
- 963 - Child Psychiatry
- 964 - Psychiatry, General
- 971 - Mental Health Clinic Treatment, State Operated
- 972 - Mental Health Day Treatment, State Operated
- 973 - Mental Health Continuing Treatment, State Operated
- 974 - Mental Health Clinic Treatment
- 975 - Mental Health Day Treatment
- 976 - Mental Health Continuing Treatment
- 977 - Mental Retardation / Developmental Disabilities Clinic Treatment, State Operated
- 979 - Mental Retardation / Development Disabilities Clinic Treatment
- 981 - Diagnostic and Research Clinic Mental Retardation, State Operated
- 983 - Specialty Clinic, Mental Retardation
- 984 - Alcoholism Clinic Treatment, State Operated
- 985 - Alcoholism Day Rehabilitation, State Operated
- 986 - Alcoholism Clinic Treatment
- 987 - Alcoholism Day Rehabilitation
- 988 - Comprehensive Alcoholism Care
- 989 - Alcoholism Detoxification (Demonstration Project)

- Rate codes EXEMPT from co-payment:

- 4060 - OMH Day Treatment, Full Day
- 4061 - OMH Day Treatment, Half Day
- 4062 - OMH Day Treatment, Brief
- 4063 - OMH Day Treatment, Home Visit
- 4064 - OMH Day Treatment, Crisis Service
- 4065 - OMH Day Treatment, Pre-admission Full Day
- 4066 - OMH Day Treatment, Collateral
- 4067 - OMH Day Treatment, Pre-admission Half Day
- 4068 - OMH / OMR Mental Health Day Treatment, Collateral Visit Brief
- 4070 - OMH Continuing Treatment, Full Day
- 4071 - OMH Continuing Treatment, Half Day
- 4072 - OMH Continuing Treatment, Brief
- 4073 - OMH Continuing Treatment, Home Visit
- 4074 - OMH Continuing Treatment, Crisis Service
- 4075 - OMH Continuing Treatment, Pre-admission Full Day
- 4076 - OMH Continuing Treatment, Collateral Visit
- 4077 - OMH Continuing Treatment, Pre-admission Half Day
- 4160 - OMR/DD Day, State Operated, Full Day

- 4161 - OMR/DD Day, State Operated, Half Day
- 4162 - OMR/DD Day, State Operated, Home
- 4163 - OMR/DD Day, State Operated, Intake
- 4164 - OMR/DD Day, State Operated, Diagnosis and Evaluation
- 4165 - OMR/DD Day, State Operated, Collateral
- 4166 - OMR/DD Day, State Operated, Full Day Subchapter A
- 4167 - OMR/DD Day, State Operated, Half Day Subchapter A
- 4170 - OMR/DD Day Treatment, Full Day
- 4171 - OMR/DD Day Treatment, Half Day
- 4172 - OMR/DD Day Treatment, Home
- 4173 - OMR/DD Day Treatment, Intake
- 4174 - OMR/DD Day Treatment, Diagnosis and Evaluation
- 4175 - OMR/DD Day Treatment, Collateral
- 4176 - OMR/DD Day Treatment, Full Day Subchapter A
- 4177 - OMR/DD Day Treatment, Half Day Subchapter A
- 5312 - TB Directly Observed Therapy NYC Level 1
- 5313 - TB Directly Observed Therapy NYC Level 2
- 5314 - TB Directly Observed Therapy NYC Level 3
- 5315 - TB Directly Observed Therapy NYC Level 4
- 5316 - TB Directly Observed Therapy NYC Level 5
- 5317 - TB Directly Observed Therapy ROS Level 1
- 5318 - TB Directly Observed Therapy ROS Level 2
- 5319 - TB Directly Observed Therapy ROS Level 3
- 5320 - TB Directly Observed Therapy ROS Level 4
- 5321 - TB Directly Observed Therapy ROS Level 5

PHARMACY SPECIFIC EXEMPTIONS:

PSYCHOTROPIC DRUGS EXEMPT FROM CO-PAYMENT REQUIREMENTS EFFECTIVE DECEMBER 1, 1992

These drugs or combinations of these drugs are exempt from co-payment. Consult the pharmacy microfiche for the New York State List of Reimbursable Drugs.

acetazolamide
acetophenazine
alprazolam
amantadine
amitriptyline
amoxapine
benztropine
biperiden
bupropion
buspirone
butabarbital
carbamazepine
chloral hydrate
chlordiazepoxide
chlormezanone
chlorpromazine
chlorprothixene
clomipramine
clonazepam
clorazepate dipotassium
clozapine
desipramine
diazepam
diphenhydramine
doxepin
estazolam
ethopropazine HCl
ethosuximide
ethotoin
fluoxetine
fluphenazine
flurazepam
halazepam
haloperidol
hydroxyzine HCl
hydroxyzine pamoate
imipramine
isocarboxazid
lithium
lorazepam
loxapine
maprotiline
mephenytoin
mephobarbital
meprobamate
methsuximide
mesoridazine
molindone
nortriptyline
oxazepam
paraldehyde
paramethadione
pentobarbital
perphenazine
phenacemide
phenelzine
phenobarbital
phensuximide
phenytoin
pimozide
prazepam
primidone
prochlorperazine
procyclidine
promazine
protriptyline
quazepam
secobarbital
sertraline
temazepam
thioridazine
thiothixene
tranylcypromine
trazodone
triazolam
trifluoperazine
triflupromazine
trihexyphenidyl HCl
trimethadione
trimipramine
valproic acid and derivatives

DRUGS FDA INDICATED FOR THE TREATMENT OF TUBERCULOSIS
WHICH ARE EXEMPT FROM CO-PAYMENT REQUIREMENTS EFFECTIVE DECEMBER 1, 1992

These drugs or combinations of these drugs are exempt from co-payment. Consult the pharmacy microfiche for the New York State List of Reimbursable Drugs.

Aminosalicylate Sodium (Para-Aminosalicylate Sodium)
Capreomycin Sulfate
Cycloserine
Ethambutol
Ethionamide
Isoniazid
Pyrazinamide
Rifampin
Streptomycin

PROVIDERS MUST NOT REDUCE THEIR MMIS CLAIMS BY THE CO-PAYMENT COLLECTED:

Providers must NOT reduce the amount charged on their Medicaid claim forms by the co-payment amount which is collected from Medicaid recipients. Each claim billed to the Medicaid Management Information System (MMIS) which requires co-payment will have a co-pay deducted from the final payment amount calculated as due from Medicaid.

DRAFT 10/5/92

Dear Pharmacy Provider:

The purpose of this letter is to inform you of important Medicaid Program policies pertaining to (1) orders from podiatrists and (2) co-payment requirements.

1. ORDERS FROM PODIATRISTS

Medicaid policy pertaining to orders for pharmacy services from podiatrists has not changed. You may continue to honor valid orders for medically necessary drugs and supplies covered under the Medicaid Program. Although podiatrists may no longer be paid for services they provide to some Medicaid recipients, pharmacy providers can continue to be paid for pharmacy services ordered by podiatrists.

2. CO-PAYMENT REQUIREMENTS

This letter serves to notify you that Medicaid co-payments will begin on December 1, 1992. Prescription drugs, nonprescription drugs, and sickroom supplies dispensed on or after November 1, 1992 will be subject to the co-payment requirements described in this letter. Please note that there have been some changes to the co-payment program since our last notice. Among the changes is a revised list of exempt psychotropic drugs and a new list of exempt drugs used to treat tuberculosis.

The Federal court has issued an order which authorizes the Department to proceed with implementation of co-payments. The court's decision terminates the previously issued temporary restraining order which delayed implementation of the State legislation pertaining to co-payment requirements. **THE LEGISLATION RETAINS THE PROVISION THAT THE PROVIDER MAY NOT DENY SERVICES TO AN ELIGIBLE RECIPIENT BASED ON THE RECIPIENT'S STATEMENT THAT THEY ARE UNABLE TO PAY THE CO-PAYMENT AMOUNT. YOU CANNOT REFUSE TO PROVIDE SERVICES TO OTHERWISE ELIGIBLE RECIPIENTS WHO INDICATE THEY CANNOT PAY OR ARE UNABLE TO PAY THE CO-PAYMENT. IF YOU REFUSE TO PROVIDE SERVICES, IT IS AN UNACCEPTABLE PRACTICE. UNDER THESE CIRCUMSTANCES, THE PROVIDER WILL BE REQUIRED TO ACCEPT THE REDUCED MEDICAID PAYMENT AS FULL PAYMENT.**

Do not deduct the co-payment collected from the amount charged on the Medicaid claim. Each claim line billed to the Medicaid Management Information System (MMIS) will have the co-payment automatically deducted from the final payment amount calculated as due from Medicaid. The details of the Medicaid co-payment requirements are as follows.

PRESCRIPTION DRUGS

CATEGORY	CO-PAYMENT
Brand Name Drugs[1]	$2.00 each new and refill Rx
Generic Drugs	$ .50 each new and refill Rx
Psychotropic Drugs[2]	Exempt
Tuberculosis Drugs[2]	Exempt
Compounded Drugs[3]	Exempt
Family Planning Drugs[4]	Exempt
Emergency Services[5]	Exempt

NONPRESCRIPTION DRUGS

CATEGORY	CO-PAYMENT
Drugs Listed In Section 4.1 Of The MMIS Pharmacy Provider Manual	$.50 each new and refill order
Family Planning	Exempt
Emergency Services[5]	Exempt

ENTERAL AND PARENTERAL FORMULAE/SUPPLIES

CATEGORY	CO-PAYMENT
Items Listed In Section 4.2 Of The MMIS Pharmacy Provider Manual	$1.00 each new and refill Rx and order
Emergency Services[5]	Exempt

SICKROOM SUPPLIES

CATEGORY	CO-PAYMENT
Items Listed In Sections 4.3 & 4.4 Of The MMIS Pharmacy Manual	$1.00 each new and refill order
Family Planning Products	Exempt
Emergency Services[5]	Exempt

Notes:

1. Any single source or innovator multiple source drug.
2. Consult attached list.
3. As defined in Sections 2.2.2 and 4.5 of the MMIS Pharmacy Manual
4. Oral contraceptive drugs and Clomid.
5. Emergency services are services which are provided after the sudden onset of a medical condition which manifests itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. **Enter code "L" in the SA Excp Code field on the claim to identify an emergency when submitting a claim to MMIS for payment.**

RECIPIENTS WHO ARE EXEMPT FROM CO-PAYMENT

1. Recipients Under Age 21:

These recipients can be identified by the date of birth printed on the plastic Common Benefit Identification Card. The date of birth will be compared with the date of service on the claim. It should be noted that refills dispensed after a recipient turns 21 will require a co-payment. **Providers do not need to enter a special code on Medicaid claims to identify these recipients.**

2. Pregnant Recipients:

Pregnant women are exempt from co-payments through the second month after the month in which their pregnancy ends. A pregnant recipient may be identified by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when a prescription/order source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. **Use the code "Z9" in the Recipient Other Insurance Code field on the claim to identify a pregnant recipient when submitting a claim to MMIS.**

3. Recipients Enrolled In Managed Care Programs And Comprehensive Medicaid Case Management Programs (CMCM):

A. Managed Care Programs - Recipients enrolled in managed care programs are exempt from co-payments. These recipients can be identified by the coverage code message received from the Electronic Medicaid Eligibility Verification System (EMEVS) when verifying eligibility. Recipients in managed care programs are identified by one of the following messages:

- ELIGIBLE PCP
- ELIGIBLE CAPITATION GUARANTEE
- ELIGIBLE PCP HR
- GUARANTEE HR

Providers do not need to enter a special code on the claim to identify recipients who are in managed care programs.

B. Comprehensive Medicaid Case Management Programs - Recipients enrolled in a Comprehensive Medicaid Case Management Program (including TASA, OMH/ICM. OMRDD/CMCM, AIDS Case Management, Onondaga County Prenatal Pediatric Case Management and CONNECT) are exempt from co-payments. These recipients are identified on EMEVS by the following responses:

"EXCEPTION CODE 35" - Designates an individual who receives CMCM
"EXCEPTION CODE 50" - Designates an individual who is eligible to receive CONNECT - Only Perinatal Family Services
"EXCEPTION CODE 51" - Designates an individual who receives CMCM under the CONNECT Program

Providers do not need to enter a special code on the claim to identify recipients who are in these programs.

4. ICF/DD and Nursing Facility Residents:

Recipients in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's) or Nursing Facilities are exempt from co-payments. Providers may verify that a recipient is a resident of a nursing facility by checking with the facility. Individuals in ICF/DD's are identified on EMEVS by the following response:

"EXCEPTION CODE 38" - Designates an individual who is a resident of an ICF/DD

Providers do not need to enter a special code on the claim to identify recipients who are in ICF/DD's or Nursing Facilities.

5. Residents of OMH and OMRDD Certified Community Residences:

Recipients who are residents in Community Residences certified by the Office Of Mental Health or the Office of Mental Retardation and Developmental Disabilities are exempt from co-payments. Each month the Community Residence will give recipients a letter to show providers which certifies that they live in a community residence and are exempt from co-payment. This letter will serve as verification that a recipient is exempt from co-payment. **Use the code "Z8" in the Recipient Other Insurance Code field on the claim to identify residents of Community Residences.**

6. Co-Payment Maximum:

Between January 1, 1993 and March 31, 1993 there will be a $50 maximum total co-payment for drugs. It is expected that few recipients may possibly reach the $50 maximum. Recipients who think they might need more than 25 prescriptions in this three month period are instructed to ask their pharmacist to help them keep a record of all prescriptions subject to co-payment. When a recipient has incurred $50 in co-payments refer to the folowing billing instructions to ensure that co-payments will no longer be deducted from your claims: **Use the code "Z7" in the Recipient Other Insurance Code field on the claim to identify recipients who have reached the $50 limit.**

Starting on April 1, 1993 there is a $100 per year maximum per recipient on ALL co-payments. The Department will record all co-payments incurred by recipients and inform providers via EMEVS when recipients have reached the maximum and no co-payment is due. Further details on how providers may access EMEVS for co-payment information will follow in future communications from the Department.

Sincerely,

Michael A. Falzano
Director
Bureau of Ambulatory Policy and
Utilization Review
Division of Health and Long Term Care

Attachments

PSYCHOTROPIC DRUGS EXEMPT FROM CO-PAYMENT REQUIREMENTS EFFECTIVE DECEMBER 1, 1992

These drugs or combinations of these drugs are exempt from co-payment. Consult the pharmacy microfiche for the New York State List of Reimbursable Drugs.

acetazolamide
acetophenazine
alprazolam
amantadine
amitriptyline
amoxapine
benztropine
biperiden
bupropion
buspirone
butabarbital
carbamazepine
chloral hydrate
chlordiazepoxide
chlormezanone
chlorpromazine
chlorprothixene
clomipramine
clonazepam
clorazepate dipotassium
clozapine
desipramine
diazepam
diphenhydramine
doxepin
estazolam
ethopropazine HCl
ethosuximide
ethotoin
fluoxetine
fluphenazine
flurazepam
halazepam
haloperidol
hydroxyzine HCl
hydroxyzine pamoate
imipramine
isocarboxazid
lithium
lorazepam
loxapine
maprotiline
mephenytoin
mephobarbital
meprobamate
methsuximide
mesoridazine
molindone
nortriptyline
oxazepam
paraldehyde
paramethadione
pentobarbital
perphenazine
phenacemide
phenelzine
phenobarbital
phensuximide
phenytoin
pimozide
prazepam
primidone
prochlorperazine
procyclidine
promazine
protriptyline
quazepam
secobarbital
sertraline
temazepam
thioridazine
thiothixene
tranylcypromine
trazodone
triazolam
trifluoperazine
triflupromazine
trihexyphenidyl HCl
trimethadione
trimipramine
valproic acid and derivatives

DRUGS FDA INDICATED FOR THE TREATMENT OF TUBERCULOSIS
WHICH ARE EXEMPT FROM CO-PAYMENT REQUIREMENTS EFFECTIVE DECEMBER 1, 1992

These drugs or combinations of these drugs are exempt from co-payment. Consult the pharmacy microfiche for the New York State List of Reimbursable Drugs.

Aminosalicylate Sodium (Para-Aminosalicylate Sodium)

Capreomycin Sulfate

Cycloserine

Ethambutol

Ethionamide

Isoniazid

Pyrazinamide

Rifampin

Streptomycin