

**NEW YORK STATE
MEDICAID PROGRAM**

**MIDWIFE MANUAL
POLICY GUIDELINES**

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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 140, Section 6951 may provide midwife services.

Midwife services may also be provided by a person practicing out-of-state who meets the qualifications for participation as a midwife in the Medicaid program in the state in which he or she is practicing. Prior approval requirements are applicable to services rendered by out-of-state providers; see **Information For All Providers, General Policy**.

Medicaid Enrollment

A midwife must be enrolled with the Department of Health (DOH), Medicaid Management Information System (MMIS), in order to be able to receive payment for services provided to a Medicaid eligible recipient. For midwife enrollment information see **Information For All Providers, Inquiry**.

Written Practice Agreement and Practice Protocols

The midwife must maintain and submit to the DOH, on request, a copy of the written practice agreement(s) with a licensed and currently registered physician(s) defining protocols for referral and consultation in the event of medical complications.

Record Keeping Requirements

Midwives 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:

- 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's 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 - Midwife Services

Under the New York State Medicaid Program, midwife services may be provided as medically indicated to eligible recipients. Midwife services are services concerned with the management of the care of mothers and newborns throughout the maternity cycle as well as services provided for primary preventive reproductive health care of essentially healthy women as set forth in State Education Law and newborn evaluation, resuscitation and referral for infants. The maternity cycle includes pregnancy, labor, birth and the immediate postpartum period. The immediate postpartum period extends a maximum of six weeks from the date of delivery. Pre and post-natal visits may include counseling about family planning services to the extent that such counseling is within the midwife's scope of practice.

Where Care May Be Provided

Midwife services may be provided in a hospital on an inpatient or outpatient basis, in a treatment and diagnostic center, in an office, or in the recipient's home.

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. Eligible women are guaranteed continued eligibility, regardless of income changes, for at least 60 days following the first day of the month after the month in which the pregnancy ends.

Medicaid Obstetrical and Maternal Services (MOMS) Program

Obstetricians, family physicians, nurse practitioners and midwives who meet certain criteria may enroll in the 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, home health and visiting nurse agencies for services such as health education, psychosocial assessment, counseling, nutrition, education, Special Supplemental Nutrition Program for Women, Infants and Children (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:

**New York State Department of Health
Bureau of Women's Health
Perinatal Health Unit, 18th floor
Corning Tower
Albany, New York 12237**

Family Planning Services

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, prescription drugs, nonprescription drugs and medical supplies prescribed by a qualified physician, physician's assistant, nurse practitioner or midwife. 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.

Standards for Providers

Family planning services can be provided by a licensed private physician, a licensed midwife, clinic or hospital which complies with all applicable provisions of law. In addition, services are available through designated Family Planning Service Programs which meet specific DOH requirements for such Programs.

Family Planning Benefit Program

The DOH implemented the Family Planning Benefit Program (FPBP) effective October 1, 2002. This program provides Medicaid coverage for family planning services to all persons of childbearing age with incomes at or below 200% of the federal poverty level. This population will have access to all enrolled Medicaid family planning providers and family planning services currently available under Medicaid.

Family planning services under this program can be provided by all Medicaid enrolled family planning providers including hospital-based and free-standing clinics, federally qualified health centers or rural health centers, obstetricians/gynecologists, physicians, nurse practitioners, licensed midwives, pharmacies and laboratories that provide family planning related services.

Specific Family Planning Services

- All FDA approved birth control methods, devices, pharmaceuticals, and supplies;
- Emergency contraceptive services and follow-up;
- Male and female sterilization in accordance with 18 NYCRR Section 505.13(e);
- Preconception counseling and preventive screening and family planning options.

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

- Pregnancy testing and counseling;
- Counseling services related to pregnancy and informed consent, and STD/HIV risk counseling;
- Comprehensive reproductive health history and physical examination, including clinical breast exam - excludes mammography;
- Screening for STDs, cervical cancer, and genito-urinary infections;
- Screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.;
- HIV counseling and testing;
- Laboratory tests to determine eligibility for contraceptive choice;
- Referral for primary care services as indicated.

A recipient may require follow-up treatment for a condition identified during the family planning visit. Medicaid payment will not be available for that follow-up treatment. NYSDOH-funded family planning providers must (based on Title X requirements) provide follow-up treatment for any STD or genito-urinary infections diagnosed during a family planning visit as part of their clinic visit rate. If an additional visit is required for the FPBP-enrolled client, Family Planning grant funds should be utilized. Treatment should be provided to the client at no cost. For providers who do not receive grant funds from the NYSDOH for family planning, treatment should either be provided, or, if necessary, clients should be referred appropriately, such as to the County Health Department, as in any other situation involving treatment of the uninsured.

Recipient Eligibility

All recipients of child-bearing age who desire family planning services are eligible for such services with the exception of sterilization (refer to sterilizations below). Family planning services including the dispensing of both prescription and non-prescription contraceptives may be given to minors who wish them without parental consent.

Medicaid eligible minors seeking family planning services may not have a Common Benefit Identification Card in their possession. To verify eligibility, the midwife or his/her staff should contact the local department of social services (LDSS). (Please see

Information For All Providers, Inquiry for the appropriate telephone number. Please obtain birthdate, sex and Social Security number of the recipient, or as much of this information as possible before contacting the LDSS.)

When HIV blood testing and pre- and post test counseling is performed as part of a family planning encounter, such services may also be obtained from any appropriate MMIS enrolled Provider without a referral 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.

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. The requirements are provided here to inform midwives who may be involved in obtaining the patient's consent.

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 (DSS3134)** 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 federallyfunded 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:

**New York State Department of Health
Corning Tower, Room 2029
Empire State Plaza
Albany, NY 12237**

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.

Hysterectomy Consent Form

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 DSS3113 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:

**New York State Department of Health
Corning Tower, Room 2029
Empire State Plaza
Albany, NY 12237**

Induced Termination of Pregnancy

Midwives may have the occasion to refer recipients for an induced termination of pregnancy. Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the DOH. Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

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." Abortion is not a covered service for women in the Expanded Eligibility Category.

Section III - Basis of Payment for Services Provided

Payment for services provided by midwives will be in accordance with fees established by the DOH and approved by the Division of the Budget. Payment for services provided by a midwife who is paid a salary/compensated by a medical facility reimbursed under the Medicaid Program for its services on a rate basis will be made on a fee-for-service basis only if the cost of the midwife's services is not included in the facility's rate.

Payment to a midwife is based upon provision of a personal and identifiable service to the recipient.

The services of midwives are reimbursable directly to the enrolled midwife or the multiservice group that employs him/her. All midwives must be enrolled in MMIS in order to bill Medicaid on a fee-for-service basis regardless of whether payment is made to them or to their employer.

Midwives who are enrolled in the MOMS program will be paid in accordance with the enhanced fees for those programs.

Reimbursement will not be made for appointments for medical care which are not kept or for services rendered to a recipient 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 Prescription Form is covered in the evaluation and management fee; additional billing to the recipient for a covered cost is an unacceptable practice.

Midwives who are enrolled in MMIS may not refuse to provide services to a Medicaid recipient because of third party liability for payment for the services. It is also contrary to state laws for a non-physician entrepreneur to employ midwives for the provision of health care services.

Furnishing or ordering medical care, services or supplies that are substantially in excess of the recipient's medical needs may result in recoupment of the cost of those services, drugs or supplies from the ordering midwife.

Payment cannot be made for medical care if the original claim is received more than two years after the original date of service.

The Department will only consider claims over two years old for payment if the provider can produce documentation explaining the cause of the delay was the result of errors by

the Department, the local department of social services, or other agents of the Department. In addition, payments will be made for claims submitted in circumstances where a court has ordered the Department to make payment.

For more information on billing claims over two years old see; Timely submission of Claims to Medicaid found in **Information For All Providers, General Billing**.

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

1. Contact the Third Party Resources worker in the local department of social services which is fiscally responsible for the MA recipient/patient;
2. Advise the Third Party worker that you would like to be paid directly by the insurance carrier for your claims because the MA recipient or legally responsible relative, has been uncooperative in the past in paying you the insurance payment that they received for your service. You will need to identify the MA recipient who is being treated in order for the local social services district to assist you;
3. 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 MA rate for the same service.

Payment for Immunization

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 Procedure Code section, under the heading, Immunization Injections.)

Effective October 1, 1994, the vaccines available without charge are distributed in New York through the New York VFC Program, administered by the DOH.

Effective April 1, 1995, for Medicaid eligibles under nineteen (19) years of age, Medicaid will not reimburse providers for the cost of vaccine which is available through VFC free of charge.

Medicaid enrolled physicians, nurse practitioners, midwives and referred ambulatory providers must be registered with the VFC program in order to receive reimbursement for administering VFC-provided vaccine to Medicaid eligibles under 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 under 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 in MMIS for the date the immunization was administered. The appropriate Evaluation and Management Service may also be billed.

Section IV – Definitions

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

Drug Utilization Review Programs

Drug Utilization Review (DUR) programs are programs 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 DOH.

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.

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 practitioner to discuss the matter. The outcome might be: not dispensing the drug, reducing the dosage, or changing to a different medication.

RetroDUR

The Retrospective Drug Utilization Review (RetroDUR) program is designed to educate practitioners by targeting prescribing patterns, which need to be improved. Under RetroDUR, a review is performed subsequent to the dispensing of the medication, while Prospective Drug Utilization Review (ProDUR) requires a review to be done prior to dispensing the prescription.

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

Maternity Cycle

The maternity cycle is a period limited to pregnancy, labor, birth and the immediate postpartum period not to exceed six weeks from the date of delivery.

Midwife

A midwife is a person who is licensed and currently registered in New York State, who is educated and trained in the discipline of midwifery and who has received approval from the Department of Education to practice as a midwife. Midwifery is defined as the management of normal pregnancies, childbirth and postpartum care as well as primary preventive reproductive health care of essentially healthy women as specified in the written practice agreement, and shall include newborn evaluation, resuscitation and referral for infants as set forth in State Education Law. A midwife practicing in a state other than New York and providing services to New York State Medicaid recipients must meet the qualifications for participation as a midwife in the other state's Medicaid program.

Ordered Ambulatory Patient

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

Ordered Ambulatory Service

An ordered ambulatory service is a specific service performed by a hospital or diagnostic and treatment center possessing an operating certificate issued by the DOH. Such service is provided on an ambulatory basis, upon the written order of a qualified physician, nurse practitioner, midwife, 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;

- Medicine services, including specific diagnostic and therapeutic procedures such as electrocardiograms, electroencephalograms, and pulmonary function testing;
- Diagnostic ultrasound services, including ultrasonic scanning and measurement procedures such as echoencephalography, echocardiography and peripheral vascular system studies;
- Psychological evaluation services, performed by a clinical psychologist, including testing;
- Therapeutic services, including radiotherapy, chemotherapy and rehabilitation therapy services; and
- Medical consultation services, including those occasions when the primary care physician perceives the need for his/her patient to consult a specialist who is employed by a hospital or diagnostic and treatment center.

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.

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.

Utilization Threshold

As of July 1, 1991, under the Utilization Threshold Program, it is 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. At this point, it will be necessary for an ordering provider, including midwives, to submit a special "Threshold Override Application" form in order to obtain additional services.

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- 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.
- 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;
 - ▶ 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 and sterilization. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease, 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, nurse practitioner, midwife, hospital outpatient department, or free-standing diagnostic and treatment center; and
 - ▶ Primary care services provided by a pediatrician or pediatric clinic.

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:

- 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

Services must be ordered in writing by a licensed physician or other person so authorized by law. 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

Drugs and Supplies

Drugs must be ordered in a quantity consistent with the health needs of the patient and sound medical practice. All ordered drugs, prescription and non-prescription, must be listed on the New York State Medicaid List of Reimbursable Drugs. A prescription or fiscal order is necessary for all drugs and supplies ordered.

A prescription or fiscal order for drugs and supplies may not be refilled unless the prescriber has indicated on the prescription/fiscal order the number of refills. A maximum of 5 refills is permitted by Medicaid for supplies, prescription and nonprescription drugs, unless a lesser quantity of refills is otherwise indicated on the prescription/fiscal order. Prescriptions and fiscal orders expire 6 months from the date written regardless of how many refills are left on the prescription.

Maximum quantities and refills allowed per prescription/fiscal order may be limited by variables including: classification as a Long Term Maintenance drug, controlled substance status, and certain limits set at the discretion of the Commissioner of Health. Certain drugs or therapeutic classes of drugs may require prior authorization.

The pharmacist shall dispense 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, prescribers 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.

Oral and faxed orders for non-prescription drugs/supplies and prescriptions for controlled substances requiring the official NYS prescription blank are not reimbursed by Medicaid. Oral and faxed orders in the following instances require a hard copy, follow-up prescription to be mailed to the pharmacy:

- Any controlled substance not requiring an official NYS blank;
- Any legend product with refills indicated;
- Any legend drug where Dispense as Written/Brand Medically Necessary is indicated.

Laboratory Tests

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

Laboratory tests ordered from an independent laboratory must be individually ordered by the practitioner.

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. 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 the test has been ordered in writing by a licensed physician or a qualified practitioner. Laboratory test orders must be written (1) on a physician's or a qualified practitioner's prescription form or imprinted stationary, with all tests to be performed individually listed and written by a practitioner, or (2) 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 (3) on a preprinted order form issued by an independent laboratory on which all tests are individually ordered.

Orders for laboratory tests must indicate the diagnosis, symptomatology, suspected condition or reason for the encounter, either by use of the appropriate ICD-10-CM code or a narrative description. Other non-specific coding 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 a valid clinical laboratory permit in the appropriate categories from the DOH.

Medicaid Transportation

Approved orderers of transportation are indicated by the chart below. Livery, ambulette and nonemergency ambulance transportation of Medicaid recipients is to be ordered only by specific medical practitioners:

Livery and Ambulette

Physician
Physician's Assistant

Nurse Practitioner
Midwife
Optometrist
Dentist

Ambulance

Physician
Physician's
Assistant
Nurse Practitioner
Midwife

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 this 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.

General Policy

When a recipient has reasonable access to the mode of transportation used for normal activities of daily living, such as shopping and recreational events, this mode should also be used to travel to and from medical appointments. A recipient is not entitled to Medicaid paid transportation for occasional travel to medical appointments, unless the lack of reimbursement would cause undue financial hardship; for example, a recipient who goes to the doctor once a month can typically be expected to pay his/her own bus or subway fare.

When ordering the appropriate mode of transportation a recipient should utilize in accessing medical care and services, a basic consideration should be the Medicaid 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.

Statewide Guidelines for Ordering Livery or Taxi Transportation:

- The recipient does not live within walking distance of the place of service, and does not have access to a personal vehicle or mass transit;
- The recipient is able to travel independently, but due to a debilitating physical or mental condition, cannot use a personal vehicle or the mass transit system. (A recipient's preference is not a legitimate reason to order livery or taxi transportation if a recipient can access a personal vehicle or mass transit);
- The recipient is traveling to and from a location which is inaccessible by mass transit, and does not have access to a personal vehicle;
- The recipient cannot access the mass transit system or a personal vehicle due to temporary, severe weather which precludes use of the normal mode of transportation;

While the above conditions may demonstrate the possible need for livery or taxi service, the functional ability and independence of the Medicaid recipient should also be considered in determining the mode of transportation required.

Statewide Guidelines for Ordering Ambulette Transportation:

- The recipient requires the personal assistance of the driver in entering and exiting the recipient's residence, the ambulette, and the medical facility;
- The recipient is wheelchair-bound (non-collapsible or one which requires a specially configured vehicle);
- The recipient has a mental impairment and requires the personal assistance of the ambulette driver;
- The recipient has a severe, debilitating weakness or is mentally disoriented as a result of medical treatment and requires the personal assistance of the ambulette driver;
- The recipient has a disabling physical condition which requires the use of a walker, crutch, or brace and is unable to use a livery service or bus.

Note: If the recipient brings an escort on the trip, and the presence of the escort obviates the need for the personal assistance of the ambulette employee, it is not appropriate to order ambulette services.

While the above conditions may demonstrate the possible need for ambulette service, the functional ability and independence of the Medicaid recipient should also be considered in determining the mode of transportation required. Additionally, other conditions not listed may require the use of an ambulette service. The key to the use of an ambulette service is that the assistance of the driver or the need for a specially configured vehicle is required. Implicit in the use of an ambulette is the need for door-to-door service. Ambulette may not be ordered based on recipient preference.

Some ambulette services provide stretcher service when the person transported must be transported in a recumbent position and is not in need of basic life support care. Persons requiring stretcher transport without the need of life support services can use these specialized ambulette vehicles.

Statewide Guidelines for Ordering Nonemergency Ambulance Transportation:

- The recipient must be transported on a stretcher and/or requires the administration of life support equipment by trained medical personnel. The use of a nonemergency ambulance is indicated when the recipient's condition would contraindicate any other form of transport.

Summary

Transportation services provided within the Medicaid program are intended to assure that recipients are able to access necessary medical care and services covered under Medicaid. Recipients who can get to medical care on their own should not have transportation services ordered for them. The transportation provided should be the least intensive mode required based on the recipient's current medical condition. You should be aware that, according to Department regulation 504.8(a):

Providers shall be subject to audit by the department and with respect to such audits will be required (2) to pay restitution for any direct or indirect monetary damage to the program resulting from their improperly or inappropriately furnishing services or arranging for ordering, or prescribing care, services or supplies.

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 midwife who is not employed by the clinic.

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, as referenced within the appropriate Provider Manual/Fee Schedule (e.g., Physician, Dental etc.). The facility will be reimbursed on a fee-for-service basis for those services rendered within the facility, in conjunction with the guidelines set forth within the Ordered Ambulatory Services Manual.

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 for any item of medical care is made only to the provider actually furnishing such care. Pharmacies may experience problems when billing for drugs ordered by midwives. It may be helpful to remind the pharmacy that the claim for Medicaid payment must show the license number of the midwife preceded by a zero. e.g., license number F340123 must be entered as 0F340123.

Should additional billing information be needed, direct inquiries by telephone, or in writing, to Computer Sciences Corporation (see **Information For All Providers, Inquiry**).

Screening Mammography

Screening Mammography is a covered service under the New York State Medicaid Program when ordered by a physician, physician's assistant, midwife or nurse practitioner. The referral 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.