Department of Health | AIDS Institute

UNINSURED CARE PROGRAMS

ADAP PLUS

PRACTITIONER AGREEMENT FORM

1-800-832-5305

Uninsured Care Programs
Empire Station, P.O. Box 2052,
ALBANY, NY 12220-0052
1-800-732-9503 / 518-459-1641
adap@health.ny.gov

ADAP PLUS PRACTITIONER APPLICATION AND AGREEMENT FORM

PROGRAM DESCRIPTION

The New York State Department of Health AIDS Institute has established five programs for HIV Uninsured Care (ADAP, ADAP Plus, the HIV Home Care Program, and the ADAP Plus Insurance Continuation Program). The mission of these programs is to provide access to medical services and care for all New York State residents with or at risk of acquiring HIV. The programs employ a dual approach to carry out their mission. First, the programs empower the individual to seek and access care by providing an "Enrollment Card", which allows the individual to choose a provider and receive care/drugs without cost. Second, the programs supply a stable and timely funding stream to health care providers, enabling them to use the revenues to develop program capacity to meet the needs of uninsured and underinsured HIV and HIV at risk populations.

PROVIDER ELIGIBILITY AND PRACTICE REQUIREMENTS

To qualify, the practitioner must:

1. Be enrolled in the New York State Medicaid Program.

2. Be board certified (or board admissible for a period of no more than five years from completion of a post graduate training program) in internal medicine, pediatrics, family practice or OB/GYN. This requirement may be waived for general practitioners currently serving Medicaid patients in areas of the state where there are insufficient numbers of Medicaid enrolled qualified primary care practitioner.

3. A nurse practitioner must have a collaborative agreement and practice protocols with a licensed Practitioner in accordance with the requirements of the NYSED.

4. Coordinate medical care services:

    a. lab services may be done by a vendor who will accept ADAP Plus fees as payment in full and not bill the patient. This may be done by:
        i. Referral of the patient to the practitioner’s regular laboratory vendor who will accept ADAP Plus fees.
        ii. Referral of the patient to a participating Article 28 Lab enrolled in ADAP Plus.

    b. lab services can be performed and billed by the practitioner, if the practitioner is considered a Certified Lab Vendor as defined by the New York State Department of Health.

5. Develop referral linkages with drug treatment programs and local community-based HIV prevention organizations.

6. Sign a written agreement with ADAP Plus, such agreement to be subject to written cancellation with 30 days notice by either party.

CLIENT ELIGIBILITY

ADAP Plus serves HIV-infected New York State residents who are uninsured or underinsured for primary medical care. Participants must meet the following criteria:

(1) Residency:	New York State (U.S. citizenship is not required.)
(2) Medical:	HIV-infection
(3) Financial:	Financial eligibility is based on 500% of the Federal Poverty Level (FPL). FPL varies based on household size and is updated annually.

- Applicants who have partial insurance or limitation that inhibit access to primary care services will be eligible for the program. Such individuals will assign their insurance benefits to the program. Their benefits will be coordinated, by the program for maximum reimbursement to the program.

- Adolescents who do not have access to the financial or insurance resources of their parents/guardians will be eligible for the program.

- Undocumented persons who may not be able to access Medicaid, Medicare or other entitlement programs will be eligible for the program.

- There are no co-payments required.

- ADAP Plus determines applicant eligibility and issues an ID card to enrolled participants.

REIMBURSEMENT and UTILIZATION LIMITATIONS

Due to Federal limitations, HIV counseling and testing services and inpatient consultations are not reimbursable under this program.

All visits are limited to a maximum of 35 per patient per treatment year. For questions regarding Program service limitations, billing or payment processes please call 1-800-832-5305.

REIMBURSEMENT and COVERED SERVICES

The services reimbursable under ADAP Plus include the following medical services, provided on an out-patient ambulatory basis. ADAP Plus uses established fee for service Medicaid rate schedules and coding for payment of covered services.

The following codes are used to report evaluation and management services provided in the **practitioner's office**. A patient is considered an outpatient until inpatient admission to a health care facility occurs. **The maximum reimbursable amount for Evaluation and Management procedure codes is dependent on the Place of Service reported.** Report the place of service code that represents the location where the service was rendered in claim form field Place of Service.

NEW PATIENT

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

99205 Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity.

<u>ESTABLISHED PATIENT</u>

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a Practitioner.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, and/or medical decision making of low complexity.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and/or medical decision making of high complexity.

LAB/ANCILLARY SERVICES

Lab or ancillary services are reimbursable if;

They are performed by an ADAP Plus enrolled lab or ancillary vendor and are covered under the program.

Lab vendors are eligible to enroll in the program if they are actively enrolled in the New York State Medicaid Program and are certified by the New York State Department of Health.

If you are currently using a lab and they are not ADAP Plus enrolled, please refer the laboratory to provider relations staff at 518-459-1641 for enrollment information.

Selected ancillary and laboratory services ordered by a Practitioner are reimbursable to enrolled providers.

HIV CLINICAL TRAINING

Information regarding trainings can be found at: www.health.ny.gov/diseases/aids/providers/training/

CONFIDENTIALITY OF PRACTIONERS

The names of practitioners who enroll in the ADAP Plus Program will not be disclosed to any agency or individual outside of the AIDS Institute or the NYS Department of Health without prior written approval of the participating practitioner except as may be otherwise required by Law. Enrolled practitioners are under <u>*no*</u> obligation to accept additional patients because of their participation in this program. <u>*If requested*</u> the Uninsured Care Programs will provide the practitioners name and phone number to enrolled participants through its hotline or online at the Department of Health website.

APPLICATION

Interested practitioners may apply to participate in ADAP Plus by completing and signing the Assurances and Agreement Form, and the Provider Enrollment Form. Make a copy for your records and return the originals to the Uninsured Care Programs:

UNINSURED CARE PROGRAMS
NYS DEPARTMENT OF HEALTH
Empire Station
P.O. Box 2052
Albany, NY 12220-0052
email: adap@health.ny.gov
fax: 518-459-7429

NOTIFICATION

A letter of decision regarding the practitioner's application will be sent by the New York State Department of Health, Uninsured Care Programs to the correspondence address as listed on the Application and contact sheet.

QUESTIONS

If additional information is required, please call provider relations staff weekdays between 9:00 a.m. and 5:00 p.m. at 518-459-1641.

Uninsured Care Program staff cannot answer specific questions concerning your eligibility for Medicaid. Inquiries regarding your Medicaid enrollment should be directed to eMedNY Provider Services Office at 1-800-343-9000.

NEW YORK STATE DEPARTMENT OF HEALTH, AIDS INSTITUTE
ADAP PLUS PRACTITIONER

ASSURANCES AND AGREEMENT FORM

Please read and signify agreement with the following assurances. Your signature at the bottom of this form is required for program enrollment.

1. I recognize that I continue to be bound by the rights, obligation and duties as a result of my enrollment in the New York State ADAP Plus Program.

2. As a qualified primary care practitioner or specialist, I assure the provision of comprehensive medical care services to ADAP Plus patients in accordance with generally accepted standards of medical practice.

3. As a qualified primary care practitioner or specialist I agree to provide medical care coordination which will include at a minimum: the scheduling of elective hospital admissions; management of and/or participation in hospital care and discharge planning; scheduling for necessary ancillary services; referrals for drug treatment and to community based AIDS service organizations; and the maintenance of a complete medical record to include but not limited notation of referrals and hospitalizations, and copies of test results and reports.

4. As a qualified primary care practitioner or specialist, I assure that I will maintain twenty-four-hour telephone coverage which will include timely access to a practitioner qualified to respond to the ADAP Plus patient's health concerns (Practitioner who is on call does not have to be enrolled in ADAP Plus). I recognize that this requirement cannot be met by a recording or referring patients to the emergency room.

5. I assure that patients enrolled in ADAP Plus will be free to choose from enrolled qualified providers or any specialist to whom they will be referred. Please note that only ADAP Plus enrolled practitioners can bill for services provided to ADAP Plus participants.

6. I recognize that the State may determine new visit types and rates during the term of this agreement.

7. I recognize that the New York State Department of Health may cancel my participation in ADAP Plus at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the ADAP Plus Program will include, but not be limited to my failure to substantially comply with the terms of participation including, failure to (a) permit access for patient record reviews or; (b) accurately and appropriately bill ADAP Plus under the reimbursement methodology within 90 days from the date service was provided. If your license has termed with NYS Medicaid, you have 30 days to update it. If your license is no longer valid with NYS Medicaid after 30 days immediate termination will occur from our program.

8. I recognize that I may request cancellation of my participation in the ADAP Plus Program giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will accompany a description of the basis for the request. I agree to continue to provide and/or arrange services for currently served patients up to the date of termination. I assure that I will assist patients to maintain continuity of care; to provide them with information to assist them in transferring their care; and to make timely transfer of their records upon request.

9. I assure that I will abide by all ADAP Plus policies, procedures, and instructions provided by the State and I agree to bill ADAP Plus in accordance with the reimbursement methodology established by the State.
   I understand and agree to comply with the standard assurances as specified in this agreement.

Signature: ____ Date: ____________

Print Name: ____________________________________Title: ________________________

New York State Department of Health
UNINSURED CARE PROGRAMS
EMPIRE STATION PO BOX 2052 ALBANY, NY 12220
Phone: 1-800-542-2437 or 518-459-1641
Fax: 518-459-7429

ADAP Plus Practitioner Enrollment Form

Please print clearly

MMIS Provider Number: ______________________________

MMIS Locator Code: __________

Practitioner License:____________________State:________DEA Number: _________________

Individual NPI:__________________________Federal Tax ID or SS #:____________________

Practitioner Name:____

Facility Name:____

Address:____

City:____________________________State:_______Zip Code +4_____________-__________

Clinic Phone: (___)____________________Clinic Fax: (____) __________________________

Credentialing/Administrative Contact:____________________________Title: _______________

Credentialing/Administrative Phone Number: (___) ____________________________________

Credentialing/Administrative Fax Number: (___) ______________________________________

Credentialing/Administrative Email: ____

Billing Contact:_____________________________________Title: ________________________

Billing Phone: (___)_____________________ Billing Fax: (___)________________________

Email:_________________________________ Group NPI: ____________________________

If this Practitioner is board certified, fill in the certification data below and submit a copy of certification by the appropriate specialty board:

Name of Board:____________________________ Certification Date:_____/_____/ __________

Name of Board:____________________________Certification Date:______/_____/ __________

Does this Practitioner wish to have the New York State Uninsured Care Programs refer ADAP Plus Participants to his/her practice? **[ ] Yes [ ] No**

Billing Address for Practitioner (if different from above):
Company Name:____
Address: ____
City: ______________________ State: _______ Zip Code: _________________
Phone: (___) _____________________ Ext: _________

Rev. 07/2021

List all additional service locations for this Practitioner. Use additional copies if needed.

Individual NPI:__________________________Federal Tax ID or SS #:_____________________

MMIS Locator Code:___________Provider Name: ______________________________________

Facility Name: ____

Address:____

City: _________________________ State: ___ ___ Zip Code +4:_____________- __________

Clinic Phone: (____)________________________Clinic Fax: (_____) _____________________

Billing Address for Practitioner (if different from above):
Company Name:____
Address:____
City: ____________________________ State: _______ Zip Code: _________________
Phone: (___) _____________________ Ext: __________

Individual NPI:__________________________Federal Tax ID or SS #:_____________________

MMIS Locator Code:___________Provider Name: ______________________________________

Facility Name: ____

Address:____

City: _________________________ State: ___ ___ Zip Code +4:_____________- __________

Clinic Phone: (____)________________________Clinic Fax: (_____) _____________________

Billing Address for Practitioner (if different from above):
Company Name:____
Address:____
City: ____________________________ State: _______ Zip Code: _________________
Phone: (___) _____________________ Ext: __________

Individual NPI:__________________________Federal Tax ID or SS #:_____________________

MMIS Locator Code:___________Provider Name: ______________________________________

Facility Name: ____

Address:____

City: _________________________ State: ___ ___ Zip Code +4:_____________- __________

Clinic Phone: (____)________________________Clinic Fax: (_____) _____________________

Billing Address for Practitioner (if different from above):
Company Name:____
Address:____
City: ____________________________ State: _______ Zip Code: _________________
Phone: (___) _____________________ Ext: __________