

PRENATAL CARE PROVIDERS Q&As

1. GENERAL

Q. What are key provisions of Chapter 484 of the Laws 2009?

A. Chapter 484 of the Laws of 2009 amended the Public Health and Social Services Law to:

- *Require the Commissioner of Health to develop and periodically update standards for the provision of prenatal care under the Medicaid program;*
- *Update the income eligibility standards for presumptive eligibility of pregnant women under the Medicaid program;*
- *Remove statutory references to the Prenatal Care Assistance Program;*
- *Move provisions regarding Medicaid reimbursement for prenatal care from the Public Health Law to the Social Services Law.*

Q. What was the intent of Chapter 484 of the Laws of 2009?

A. The intent of the Law was to transition the Prenatal Care Assistance Program (PCAP) to a model of care designed to ensure that **all** low income pregnant women access comprehensive prenatal care, regardless of where they seek care. The bill requires the Department of Health to update prenatal care standards and clarifies that **all** Medicaid providers, not just those formerly designated as PCAP providers – adhere to such updated standards. The law also all Article 28 providers of prenatal care enrolled in Medicaid to conduct presumptive eligibility determinations for pregnant women.

Q. What is the status of the new prenatal care standards?

A. In conjunction with stakeholders, the Department has developed and adopted new comprehensive prenatal care standards that all Medicaid providers must adhere to. The standards are posted on the DOH Website and published in a special edition of the Medicaid Update. These new standards include many of the elements contained in the original PCAP standards including the requirements for comprehensive risk assessment, health education, care coordination, etc.

Q. What does this mean for Article 28 providers that had a PCAP designation?

A. PCAPs will no longer be recognized by New York Medicaid as designated specialty prenatal clinics, but will continue to be reimbursed for the provision of comprehensive prenatal care to pregnant women, consistent with the new prenatal care standards. Article 28 providers will be reimbursed for prenatal care through the Ambulatory Patient Groups (APG) payment methodology.

Q. Will the DOH continue to certify or approve new PCAP Program?

A. No, the DOH will no longer certify or approve PCAP programs. Article 28 facilities providing prenatal care services must have prenatal services included on their operating certificate for all clinic sites offering prenatal care services. To bill Medicaid for such services, an Article 28 provider must be enrolled as a Medicaid provider.

Q. What is an Article 28 provider?

A. An Article 28 provider is a general hospital or free-standing diagnostic and treatment center certified to operate in New York State pursuant to Article 28 of the NYS Public Health Law. All Article 28 facilities have an operating certificate from the Department of Health. Article 28 facilities that provide prenatal care must be certified by the DOH to provide prenatal care and such certification should be reflected on the facility's operating certificate for all sites providing prenatal care.

Q. How can an Article 28 amend its operating certificate to reflect prenatal care?

A. Please contact the Office of Health Systems Management at (518) 402-0911 for information on how to amend an operating certificate to reflect prenatal care.

Q. Do the new prenatal standards apply to office-based practitioners and managed care plans enrolled in Medicaid or do they only apply to Article 28 providers?

A. The new prenatal care standards apply to all prenatal care providers enrolled in Medicaid including office based practitioners and managed care plans.

Q. Where can I find the prenatal care standards?

A. The prenatal care standards are available online at:

http://www.nyhealth.gov/health_care/managed_care/docs/nys_medicaid_prenatal_care_standards.pdf

http://www.nyhealth.gov/health_care/medicaid/program/index.htm

Q. How can providers learn more about the new Medicaid prenatal care standards; new requirements for Medicaid enrolled Article 28 providers of prenatal care to perform presumptive eligibility determinations; and Medicaid prenatal care coverage and payment policy?

A. The Department has taken a number of steps to communicate information to providers of prenatal care in the Medicaid program.

- A special edition of the Medicaid Update on Prenatal Care was issued in February 2010, and reissued in April 2010. Please visit: http://nyhealth.gov/health_care/medicaid/program/index.htm
- Webinars to train providers were conducted in early February. Please visit: http://nyhealth.gov/health_care/medicaid/rates/index.htm
- Targeted mailings were sent to former PCAP providers and all Article 28 clinics informing them of new presumptive eligibility determination requirements and how to obtain staff training. Please visit: <http://www.nyhealth.gov/nysdoh/perinatal/en/pcapcover.htm>
- Frequently asked questions and new Medicaid coverage and billing guidance targeted to prenatal care providers have been developed and are available at: <http://www.nyhealth.gov/nysdoh/perinatal/en/pcapcover.htm>

If you have questions after reviewing these informational materials, you may direct them as follows:

Topic	Contact
Prenatal Care Standards	Office of Quality and Patient Safety (OQPS), Office of the Medical Director (518) 486-6865
Presumptive Eligibility	Office of Health Insurance Programs (OHIP), Division of Coverage and Enrollment (518) 474-8887
Coverage and Payment Policy	OHIP, Division of Financial Planning and Policy (518) 473-2160

2. PCAP TRANSITION ISSUES

Q. Will PCAPs still exist despite the elimination of the enhanced Medicaid rates?

- A.** The Department of Health recognizes the important role that PCAPs have played in New York's prenatal health care system. Since its inception, PCAP providers have assured thousands of low income pregnant women access to timely, comprehensive, quality prenatal care. (Chapter 484 of the Laws of 2009 was recently enacted to expand access to comprehensive, quality prenatal care to all pregnant women that qualify for Medicaid, regardless of where or from whom they obtain care. The legislation eliminates the PCAP designation, certification and associated enhanced global rates, and transitions to a model of prenatal care designed to ensure that all low-income pregnant women qualifying for Medicaid, not just those served in PCAP clinics, receive comprehensive, high quality, prenatal and postpartum care.

PCAPs will not be recognized by New York Medicaid as designated specialty prenatal clinics, but will continue to be reimbursed for the provision of comprehensive prenatal care to pregnant women through the APG payment methodology. Prenatal care providers will be paid for the specific services delivered using the APG methodology.

Q. What does PCAP Transition/Close Out mean for Article 28 providers that had a PCAP designation?

- A.** PCAPs will no longer be recognized by New York Medicaid as designated specialty prenatal clinics but will continue to be reimbursed for the provision of comprehensive prenatal care to pregnant women, consistent with the new prenatal care standards, through the APG payment methodology. PCAPs will bill Medicaid as any other Article 28 provider of prenatal care services using APG rate codes.

Q. Will there continue to be a contractual relationship between the former PCAP entities and the State Department of Health?

- A.** No, there will no longer be contractual relationships between prenatal care providers and the DOH.

Q. Will the Department of Health continue to certify or approve new PCAP programs?

- A.** The Department of Health's Bureau of Women's Health will no longer certify or approve PCAP programs. All Article 28 facilities providing prenatal services must have prenatal services included on their operating certificate for all clinic sites offering prenatal care services. Facilities should contact the Office of Health Systems Management at: (518) 402-0911 to determine the appropriate approval process for changes to service sites.

Q. Will PCAP providers continue to be obligated to submit data and other reports to Department of Health? Will there be site visits?

A. PCAPs will be required to submit a 2009 annual report but subsequent annual PCAP reports will not be required. The Division of Family Health's Regional nurses will discontinue monitoring prenatal care clinics which previously had a PCAP designation. However, all prenatal care providers will be subject to monitoring and oversight for adherence to the new prenatal care standards. The Department's Office of Health Insurance Programs, in conjunction with the Department's Office of Health Systems Management, will be responsible for oversight of the delivery of Medicaid prenatal care. Details of how many prenatal care clinics will be surveyed and the tool to be used for medical record review are still to be determined.

Q. When will PCAP rate codes be end-dated and when must PCAP providers convert to use of APGs?

A. PCAP rate codes were end-dated for hospital OPDs effective December 1, 2008, when APGS were implemented. PCAP rate codes will be end-dated for D&TCs effective September 1, 2009, but this will not occur until December 1, 2010. D&TC sponsored PCAP clinics must start using the APG rate codes instead of the PCAP rate codes effective December 1, 2010.

Q. Can FQHCs opting out of APGs stop using PCAP rate codes?

A. Pursuant to federal law, FQHCs have the option of choosing APGs or the current prospective payment system (PPS) to be reimbursed for ambulatory care services. PCAP rate codes will be end-dated for all FQHCs—both those that opt to use APGs and those that don't. FQHCs that opt out of APGs will bill for prenatal care services using their PPS rates effective September 1, 2010.

3. PRESUMPTIVE ELIGIBILITY

Q. What is presumptive eligibility?

- A.** Presumptive eligibility is a way to seek immediate Medicaid coverage for a pregnant woman who presents for prenatal care services, pending a full Medicaid eligibility determination by the local social services department. A trained Article 28 prenatal care provider approved by the Department of Health will assess the pregnant woman's income and if, married, the spouse's income. The pregnant woman does not need to provide documentation of income for the presumptive eligibility determination. Based on the income assessment, the provider determines if the woman is presumptively eligible for all ambulatory services under Medicaid or for a limited array of medical services under Medicaid, following the guidelines established by the Department of Health. The presumptive eligibility screening check list, completed by the prenatal care provider, must be sent to the local department of social services within five business days so the local department of social services can authorize the presumptive eligibility coverage timely. The effective date of presumptive eligibility is the date the prenatal care provider makes the presumptive eligibility determination.

For the pregnant woman to continue her Medicaid coverage past the period of presumptive eligibility, she must complete the full Medicaid application, submit required documentation to the local social services department and meet the eligibility requirements for Medicaid.

Q. Are all Article 28 providers of prenatal care required to perform presumptive eligibility determinations for pregnant women? When is this new requirement effective?

- A.** Yes, Chapter 484 of the Laws of 2009, signed by the Governor on October 9, 2009, requires all Medicaid enrolled licensed Article 28 providers that provide prenatal care to perform presumptive eligibility determinations for pregnant women that present for prenatal care. This requirement is effective immediately. In addition to screening pregnant women for Medicaid presumptive eligibility, prenatal care providers must: (1) assist pregnant women who screen eligible in completing the Medicaid application form (DOH-4220) and in selecting a Medicaid managed care plan, and (2) submit the completed Medicaid application to the appropriate local department of social services for a full Medicaid eligibility determination.

Q. Is a copy of the letter that was sent to Article 28 providers advising that they must provide Presumptive eligibility determinations available online?

- A.** Yes, a copy of the letter is available online at:
http://www.health.state.ny.us/health_care/medicaid/rates/apg/index.htm#

Q. What steps must a Medicaid enrolled Article 28 provider of prenatal care take to meet the new statutory requirement to perform presumptive eligibility determinations for pregnant women?

A. All Medicaid enrolled Article 28 providers of prenatal care are responsible for designating staff to complete the online presumptive eligibility training available at: <http://www.bsc-cdhs.org/eLearning/>. The Department of Health will monitor the extent to which Article 28 designated staff register and complete presumptive eligibility training at the e-learning portal. Upon completion of the training modules, trainees will be given a certificate of training completion that they will use with the local department of social services to process presumptive eligibility applications.

Q. How will prenatal clinics be reimbursed for presumptive eligibility determinations under APGs?

A. While Medicaid enrolled Article 28 providers are required by state statute to perform presumptive eligibility determinations and to assist women in submitting appropriate documentation to the local social services district, they will not be reimbursed for these activities. A presumptive eligibility determination is not considered a medical service and is not reimbursable under APGs.

Q. When a patient states she is pregnant, is an estimated date of conception needed to go forward with the presumptive eligibility?

A. Yes.

Q. Can PE be given to a patient without an estimated date of conception?

A. No

Q. Is there an application form to become a presumptive eligibility provider?

A. Yes, the presumptive eligibility application form is available on the portal training Website at: <http://www.bsc-cdhs.org/eLearning/>

Q. How will patients fill scripts during their PE period?

A. Pharmacies who will honor a piece of paper showing eligibility are difficult to find therefore, PE providers should form relationships with local pharmacies to ensure prescription coverage while the pregnant woman is waiting for her MA card.

Q. Can community health workers train for presumptive eligibility to start clients in the Medicaid application process?

A. If community health workers are employed by the Article 28 clinic that provides prenatal services, they may provide PE services for the Article 28 upon completion of the required training.

Q. For purposes of PE determinations for Medicaid coverage, are Long Island facilities considered under the jurisdiction of NYC?

A. No, the county of residence of the pregnant woman determines which local social services district (Nassau Co., Suffolk Co., or HRA in NYC) is responsible for the final eligibility determination.

Q. Will undocumented pregnant women continue to be eligible for prenatal care coverage?

A. Yes, undocumented women continue to be eligible for Medicaid coverage while pregnant through the 60 day post partum period.

Q. Is the PE check list submitted separately or with the completed application?

A. The application is submitted and includes the presumptive eligibility worksheet. Coverage is put back to the beginning of the presumptive period. If the case cannot be completed and is eligible for presumptive coverage only, we put up the coverage for the presumptive period. For additional information, please contact Tina Dukes at dukest@HRA.NYC.GOV.

Q. How often is presumptive eligibility training required? What kind of documentation is required?

A. Initial presumptive eligibility training is required in order for an individual to be authorized to do PE, and refresher training is recommended every few years. The certificate of completion of PE training must be kept on file for each individual performing PE screening.

Q. Is there a change of coverage for prescriptions while a pregnant woman waits for full Medicaid eligibility?

A. No, prescriptions that are covered by Medicaid are also covered during the PE period. It is recommended that prenatal care providers that perform PE develop relationships with local pharmacies to ensure prescription coverage while the woman is waiting for her Medicaid card.

Q. If a facility is already a PE provider, does each case manager have to go through new training?

A. Yes, training is required for each individual that will be doing presumptive eligibility.

Q. Does the training have to be repeated for employees who have already taken it?

A. If you are currently submitting PE screening applications there should be no problem continuing to do so. However, it is a good idea to retake the training.

Q. Are presumptive eligibility applications submitted through edits or should they be sent manually?

A. The presumptive eligibility cases that are only eligible for presumptive coverage will need to be submitted manually, but cases with complete applications can be submitted either through EDITS or manually. For additional information please contact Tina Dukes at dukest@HRA.NYC.GOV.

Q. How is the PE process handled when a woman comes in with significant clinical symptoms that would make it hard to do the PE?

A. It is important to do presumptive eligibility for immediate coverage.

Q. When performing a PE screen for prenatal care coverage, does a provider have to be a “facilitated enroller” to help a woman choose a managed care plan?

A. No

Q. During the presumptive eligibility period, would a woman be able to choose another prenatal care provider while waiting for her Medicaid card?

A. Yes

Q. Who can I call for more information about presumptive eligibility determinations?

A. You may contact the Division of Coverage and Enrollment by calling (518) 474-8887 or via e-mail to: pwp02@health.state.ny.us.

Q. Are prenatal care providers now doing Medicaid applications for all types of patients?

A. Presumptive eligibility applications will only be taken for pregnant women. Presumptive eligibility is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. Presumptive Medicaid eligibility begins on the date the prenatal care provider makes the presumptive eligibility determination

Q. Does Medicaid coverage end after the postpartum visit?

A. Medicaid coverage continues for the client up to 60 days post partum. She can apply for Medicaid eligibility prior to the end of her 60 days post partum coverage.

Q. Can non-documented aliens apply for presumptive eligibility?

A. A woman with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends. Pregnant women are not asked about their citizenship or immigration status when applying for Medicaid, therefore it wouldn't be known that the woman is undocumented.

Q. What form of proof of pregnancy is acceptable to presume eligibility?

A. An estimated date of conception entered on the screening worksheet serves as documentation.

Q. How will payment be reimbursed for those visits that result in denial of eligibility even though PE was satisfactorily done?

A. Visits are covered during the PE time regardless of ongoing MA eligibility.

Q. Is there a presumptive eligibility for the infant if the mother is on Medicaid, so that the infant could be discharged with needed medication? How quickly does it take to get the infant on Medicaid? (HIV-exposed newborns must be discharged with a 6 week supply of zidovudine [and maybe another HIV medication] to prevent transmission of HIV from the infant's mother to the infant. There have been several instances where a birth facility had difficulty getting the medication for the infant because the infant did not have a Medicaid number.)

A. If the mother is on Medicaid when the baby is born, state law requires the hospital to report the birth via the electronic birth certificate filing process. Through a system interface this ensures the automatic Medicaid coverage of the newborn. The newborn is entitled to Medicaid for 1 year.

Q. For pregnant women who have a private doctor and go to an Article 28 clinic to apply for Medicaid, can a presumptive eligibility determination be performed or are presumptive eligibility determinations only for the Article 28 clinic patients?

A. Presumptive eligibility is determined for any pregnant woman at the first medical visit when the estimated date of conception is established. An Article 28 can perform PE for a pregnant woman. However, the goal of PE is to enable these women to obtain care immediately after presenting to the prenatal care provider. It is assumed that the Article 28 will provide prenatal care on that day.

4. APG PAYMENT METHODOLOGY

Q. What does APG refer to?

A. Ambulatory Patient Group.

Q. How will D&TCs submit claims for prenatal services while the Department of Health is waiting for CMS approval for billing under APGs?

A. Until the APG payment methodology is approved for implementation in D&TCs by CMS, the current prenatal care billing guidelines and PCAP rate codes are still in effect. Current PCAP rates include sonograms, non-stress tests, lab work and IVs and some other items that cannot be itemized on a claim.

Q. If an FQHC has opted out of APGs, how are prenatal care services billed?

A. If a FQHC has opted out of APGs, the FQHC's prospective payment system rate should be billed to Medicaid covering all prenatal services. Rate code 4013 (individual threshold visit) should be billed for a prenatal care visit.

Q. Should each ante partum visit be charged separately with an E&M visit CPT code and diagnosis code for routine prenatal care?

A. Clinics should bill an E&M code for each ante partum visit along with any other CPT codes reflecting services performed during the visit. Physicians should follow these guidelines when billing for professional services for an ante partum visit:

- *Prenatal care providers who perform less than 4 ante partum visits should bill the appropriate E&M code for the visit.*
- *Prenatal care providers performing the initial ante partum encounter and up to 5 subsequent encounters should bill CPT 59425 (4-6) visits*
- *Prenatal care providers performing the initial ante partum encounter and up to 7 or more subsequent encounters should bill CPT 59426 (7 or more) visits.*

Q. How are physicians' services billed for prenatal care services under APGs? When can supervising or managing physicians bill?

A. Effective February, 2010, a physician's professional services are carved out of the APG payment to hospital outpatient departments and physicians may use the Medicaid fee schedule to bill for their services. However, in diagnostic and treatment centers, a physician's professional services are included in the APG payment to D&TCs.

If the supervising/teaching physician is billing Medicaid and being paid under the Physician fee schedule for services provided in a clinic setting by a resident/intern, the supervising/teaching physician is required to document at least the following:

- *That the supervising/teaching physician performed the service or was physically present during the key or critical portions of the service, when performed by the resident/intern, and;*
- *The extent of the supervising/teaching physician's participation in the management of the patient.*

Additional information regarding billing Medicaid by a supervising/teaching physician can be found in the June 2009 Medicaid Update. The article is available online at:

http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-06.htm

Q. Can a radiologist bill for the professional component of a sonogram under APGs?

- A.** All professional services provided by a radiologist are carved out of APGs. For radiology procedures provided to patients in a hospital outpatient clinic or D&TC, the radiologist should bill the professional component for the sonogram using the radiology fee schedule.

Q. Does the new legislation eliminating PCAP designations also affect MOMS Providers?

- A.** Private practitioners who are enrolled as MOMS providers and receive enhanced payment for prenatal care are not affected by the new prenatal care legislation and APG billing requirements. However, the new prenatal care standards are applicable to any Medicaid provider of prenatal care including private practitioners.

Q. If an FQHC has opted not to transition to the APG methodology and uses their PPS rate to bill for prenatal care, are they expected to cover the cost of the laboratory tests and radiology studies within their PPS rate?

- A.** Facilities should confirm with OHSM what is in their PPS rate. Please contact the Bureau of Primary and Acute Care reimbursement at: (518) 474-3267.

Q. For a FQHC opting out of APG's, how will the ancillary services be handled? Will the vendors now bill Medicaid directly? If the D & TC is providing the ultrasound services, can they now bill as referred ambulatory?

- A.** The ultrasound is always included in the prospective payment system rate even if the patient is referred to an outside provider for an ultrasound. The FQHC is responsible for the cost of the ultrasound regardless if it is performed by an FQHC or an outside vendor.

Q. Is prenatal APG reimbursement also retroactive to September 1, 2009, for Article 28 D&TCs? This could be problematic regarding ancillary services and costs.

A. APGs will be implemented in D&TCs retroactive to September 1, 2009. D&TCs will be reimbursed under APGs without regard to the ancillary billing policy. See detailed billing instructions for implementation of APGs on the Department's APG Website.

Q. Does the supervising/attending physician of residents need to physically see all prenatal patients in order to bill for their services or can they perform the precepting function verbally?

A. In order to bill for a resident's services, a supervising/teaching physician must personally document that he/she performed the service or was physically present during key or critical portions of the service when the service was performed by the resident.

Q. Can the actual date of the ancillary service be reassigned to the date of service of the medical visit when the service is provided prior to the medical visit (having standard prenatal labs done prior to seeing the physician) ?

A. An episode of care is defined as all the medical or significant procedures that occur on a single date of service and any associated ancillary services that occur **on or after** the date of the medical visit and/or significant procedure. A provider cannot reassign the date of an ancillary service to the date of a medical visit if the ancillary service is provided prior to the medical visit.

Q. Is there a billing code for a prenatal or postpartum home visit?

A. Prenatal or post-partum home visits can only be ordered by a physician. Certified Home Health Agencies (CHHAs) enrolled in Medicaid and/or Medicaid enrolled licensed home care agencies under contract with CHHAs provide the home visits. The CHHAs bill for the home visits using the appropriate rate code.

Q. If a FQHC has opted out of APGs, how are prenatal care services billed?

A. If a FQHC has opted out of APGs, the FQHC's prospective payment system rate should be billed to Medicaid covering all prenatal services.

Q. What is the impact of APGs on the new prenatal care standards?

A. APGs will have a net positive impact on outpatient clinics and encourage the provision of comprehensive prenatal care services. The APG payment methodology will pay more for higher cost services, less for lower cost services, and will adjust over time to reflect changes in standards of care and service delivery. Under APGs, Article 28 prenatal care providers will be paid for services coded on their claims, including ancillary lab or radiology services ordered for their pregnant patients.

Q. Will there still be three types of rates: initial, follow-up, and post partum?

- A. Upon APG implementation, PCAP rate codes **3101, 3102, and 3103** (initial, follow-up, and postpartum visits) are end dated and replaced with new APG visit and episode rate codes. APG visit rate codes should be billed for recipients that have both Medicare and Medicaid coverage. APG episode rate codes must be billed for Medicaid-only recipients. The table below identifies the APG rate codes that should be billed by hospital outpatient department and D&TC prenatal care providers.

SETTING	SERVICE	NEW APG VISIT RATE CODE*	NEW APG EPISODE RATE CODE*
Hospital	Outpatient	1400	1432
Free-Standing D&TC	Clinic	1407	1422

*Episode rate codes must be used by January 1, 2011, except for claims for Medicare/Medicaid dually eligible patients. Those claims should always be submitted to eMedNY using APG visit rate codes.

Q. With the initial visit, are there APG codes for each separate service completed or are some services included in the initial visit APG reimbursement?

- A. Every single service provided during a patient encounter, including ancillary services, must be identified on the APG claim with the appropriate Current Procedural Terminology (CPT) code to insure correct payment.

Q. Will all prenatal visits be assigned the same APG and do all APGs have the same weight?

- A. The two prenatal APGs, 765 (Routine Prenatal Care) and 766 (Other Ante partum Diagnoses) are assigned different weights. APG assignment will be determined by the primary diagnosis code and CPT-4 or HCPCS procedure codes billed.

Q. What is APG “blending”?

- A. APG reimbursement for prenatal care services provided by hospital OPDs and D&TCs (upon CMS approval) is being phased in. Effective December 1, 2009, the payment for each individual visit was based on 50% of the full amount that the APG methodology would pay for the visit (based on coded procedures and diagnoses) and 50% of the provider’s average per visit reimbursement for services prior to APG implementation. On January 1, 2011, the APG portion of the blend will increase to 75%; and on January 1, 2012 to 100%.

Q. Do prenatal care providers need to bill the capital add- on in addition to specific APG rate codes?

- A. Prenatal care clinics should not bill the capital add-on in addition to the specific APG rate code. When eMedNY processes the claim, the system will automatically calculate the capital add-on amount with the APG payment.

Q. When a clinic provides both medical and dental services to a patient on the same date of service, how should the two distinct services be billed?

A. Dental and other clinic services provided on the same date of service (and associated ancillaries, regardless of their dates of service) must be billed together on a single claim using an APG rate code. Dental and medical visit procedure codes group to different APGs and, beginning 1/1/10, non-dental medical visits pay at the line level even when coded on the same claim as dental procedures and/or exams.

Q. How will clinics providing prenatal care services submit claims and be paid for physician services?

A. For prenatal care provided in D&TCs, the payment for professional physician services is included in the APG payment to the clinic. The APG payment to the D&TC clinic is considered payment in full, and the physician is prohibited from submitting a separate claim to Medicaid. Effective February 1, 2010, physician services are carved out of the APG payment to hospital outpatient clinics; physicians providing prenatal care in hospital OPDs may bill for their professional services using the Medicaid fee schedule.

Q. How can a facility bill for a prenatal care clinic visit in the morning and then a delivery in the evening in the hospital?

A. In the situation described above, two separate claims should be submitted to Medicaid. One claim would be submitted for the clinic visit and the second claim would be submitted for the inpatient delivery.

Q. Should managed care plans bill using APGs?

A. Medicaid Health plans do not have to use the APG payment methodology to reimburse network providers for the provision of prenatal care services. To the extent that Medicaid health plans are statutorily or contractually required to pay providers the Medicaid rate of payment for covered services provided to plan enrollees, plans will need to determine the appropriate Medicaid payment under APGs.

Q. As far as billing goes, what changes once a patient becomes enrolled in a Medicaid managed care plan?

A. Once a pregnant woman is enrolled in managed care, the managed care plan is responsible for her care. A "transitional care" benefit is afforded to newly enrolled women who have entered their second trimester of pregnancy that allows continuity of care in cases where the woman's health care provider does not participate with the managed care plan. Specifically, managed care plans are required to allow women who have entered their second trimester of pregnancy as of the effective date of enrollment, and who have an existing relationship with a provider who does not participate in the plan's network, to continue to see the non-participating provider for a transitional period that continues for the remainder of the pregnancy, including the delivery, and for post-partum care directly related to the delivery.

This requirement applies as long as the non-participating provider agrees to: accept the plan's rates of payment as payment in full (the payment must be no more than the rates paid to similar providers within the plan's network); adhere to the plan's quality assurance requirements; provide the plan with necessary medical information concerning the enrollee's care; and, adhere to the plan's other policies and procedures, such as procedures regarding referrals and obtaining pre-authorization for treatment.

Q. Will pregnant patients have utilization thresholds?

A. Prenatal care services are exempt from the utilization threshold program.

Q. Can a medical visit and a carved out visit be on the same claim or does it need to be split?

A. The medical visit would be billed under APGs on a separate claim. The carved out visit would be billed fee-for-service on a different claim.

Q. Will APG billing allow for reimbursement of childbirth education classes?

A. Medicaid does not reimburse for Childbirth Education classes.

Q. Are quad alpha-fetoprotein screening tests carved out of APGs as a genetic test?

A. The quad alpha-fetoprotein screening tests are not carved out of APGs.

Q. How do APGs affect an office based practitioner's billing on a fee- for-service?

A. Private practicing practitioners will continue to bill Medicaid using the physician fee schedule.

Q. Can we bill for services performed by nurse practitioners or physician assistants if the doctor is not on-site at the time of service?

A. Yes, hospital OPDs and clinics can bill for services under these circumstances.

5. PRIMARY CARE ENHANCEMENTS

Q. Are there new Medicaid benefits for pregnant women?

A. Medicaid coverage has been expanded to include:

- *coverage of and reimbursement for smoking cessation counseling for pregnant and post partum women (up to 6 months) and children up to the age of 21;*
- *asthma and diabetes self- management training by certified asthma and diabetes educators;*
- *mental health counseling for pregnant and postpartum women (up to 60 days) and children and adolescents up to the age 21 by Licensed Master Social Workers and Licensed Certified Social Workers,*
- *and payment for expanded 'after-hours access' to primary care.*

Diabetes Education

Q. Will diabetes education be covered for clients with gestational diabetes? Will it be part of a bundled rate visit, or can it be a separate charge on a separate day?

A. Diabetes education provided by Certified Diabetes Educators (CDEs) is a covered Medicaid service effective January 1, 2009. Diabetes education groups to an APG and is a line item payment. Detailed coverage and billing information is available in the October and December 2009 Medicaid Updates. Diabetes education will be paid under APGs using the appropriate HCPCS codes:

- **G0108** - *Diabetes outpatient self-management training services, individual, for 30 minutes*
- **G0109** - *Diabetes outpatient self-management training services, group <=8 patients per 30 minutes*

These procedure codes can be billed on the same day with an evaluation and management visit or as a stand-alone service with a separate line charge. These procedure codes must be listed on one claim line with the appropriate number of units. There is a maximum of 4 units (2 hrs.) per day for each procedure code billed on one APG claim. There is additional information in the Medicaid Update. The links to the Medicaid Update articles for diabetes and asthma self management is:

http://www.nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#don

http://www.nyhealth.gov/health_care/medicaid/program/update/2008/2008-12.htm#cer

Asthma Education

Q. Will asthma education be covered under Medicaid?

- A.** Asthma self- management training services (ASMT) are now available for all Medicaid beneficiaries diagnosed with asthma when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or a licensed midwife. These services are available in physicians' offices and hospital OPDs and in D&TCs upon APG implementation. A Federally Qualified Health Center (FQHC) may bill for this service ONLY if it has elected to be reimbursed under APGs. Self-management training services are to be provided by a New York State licensed, registered, or certified health care professional, who is also certified as an educator by the **National Asthma Educator Certification Board (CAE)**.

A beneficiary with newly diagnosed asthma or a beneficiary with asthma who has a medically complex condition (such as: an exacerbation of asthma, poor asthma control, diagnosis of a complication, etc.) will be allowed up to 10 hours of ASMT during a continuous 6-month period. Beneficiaries with asthma who are medically stable may receive up to 1 hour of ASMT in a continuous 6-month period. Self-management training services may be provided in individual sessions, or in group sessions of no more than eight patients.

Smoking Cessation

Q. Is smoking cessation counseling covered by Medicaid?

- A.** Yes.

Q. What is the smoking cessation benefit?

- A.** Smoking cessation counseling coverage is currently available for pregnant and postpartum women, up to 6 months post-partum, who are receiving care in hospital outpatient department clinics. Coverage of this service in D&TCs will be available upon APG implementation (effective upon CMS approval). Medicaid will pay for up to 6 counseling sessions within a 12 month period.

Q. How is smoking cessation billed under APGs?

- A.** Providers should bill for these services under APGs using CPT procedure codes:
- 99406 (*smoking cessation counseling, 3-10 minutes*)
 - 99407 (*smoking cessation counseling, greater than 10 minutes*).

Detailed coverage and billing information may be found in the October 2009 Medicaid Update. The link to the Medicaid Update is:

http://www.nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#don

Q. Do managed care plans cover smoking cessation counseling for pregnant and postpartum women?

A. Yes, managed care plans should pay the prenatal care provider for smoking cessation counseling.

Q. What mental health services are available to pregnant women?

A. Effective for dates of service on or after September 1, 2009, Medicaid reimbursement is available for mental health counseling to pregnant women provided by Licensed Clinical Social Workers (LCSWs) and Licensed Master Social Workers (LMSWs) under the direction of a LCSW, psychiatrist, or a psychologist. Reimbursement will cover mental health counseling services provided to pregnant or postpartum women, up to 60 days post-partum (based on the date of delivery or end of pregnancy). The levels of mental health counseling are as follows:

- **Individual brief counseling** (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face with the patient).
- **Individual comprehensive counseling** (psychotherapy which is insight oriented, behavior modifying and/or supportive approximately 45-50 minutes face-to-face with patient).
- **Family counseling** (psychotherapy with or without patient).

Detailed coverage and billing information is available in the March 2009 Medicaid Update available online at:

http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-03.htm#med

Q. Is mental health counseling required to be on the Article 28 clinic operating certificate? How will Article 28 clinics be reimbursed for mental health counseling for LCSW and LMSW with supervision?

A. In order to provide mental health counseling, the Article 28 clinic must have psychiatry or psychology on their operating certificate. Payment will not be reimbursed under APGs. These services will instead be reimbursed using the rate codes identified below. An LMSW must be supervised by a LCSW, psychiatrist, or psychologist in order to bill Medicaid for mental health counseling. If a prenatal care service is provided on the same date of service as mental health counseling by a LCSW/LMSW, two claims should be submitted – one APG claim for the medical/prenatal care encounter, and a separate claim for the mental health counseling.

- 4257 *Individual brief counseling;*
- 4258 *Individual comprehensive counseling*
- 4259 *Family Counseling*

Note: Mental health counseling provided by LCSW/LMSW is limited to recipients who are pregnant (through 60 days postpartum) and/or children and adolescents up to 21 years of age.

Q. Will clinics be reimbursed if a pregnant woman needs services after usual office hours?

- A.** Yes, a supplemental payment amount is available for prenatal care appointments scheduled to occur on evenings, weekends and holidays as defined by the Department of Health. This payment is effective for patient visits in physician offices and hospital OPDs for services provided. Patient visits in D&TCs will be eligible for this additional reimbursement for services provided upon implementation of APGs. This payment will be added to the otherwise applicable payment amount for each such visit. NOTE: A FQHC may bill for this service ONLY if it has elected to be reimbursed under APGs. Clinic reimbursement for expanded hours access will be added to a facility's APG payment for services rendered.

For purposes of receiving the enhanced fee, evenings, weekends, and holidays are defined as follows:

- *An evening visit is one which is scheduled for and occurs after 6:00 p.m.*
- *A weekend visit is one which is scheduled for and occurs on Saturday or Sunday.*
- *A holiday visit is one which is scheduled for and occurs on a designated national holiday.*

Detailed coverage and billing information may be found in the following Medicaid Update: The link is available online at:

http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-12.htm#inc

6. MEDICAID PRENATAL CARE PAYMENT POLICY FOR HEALTH SUPPORTIVE SERVICES

Q. Will office-based practices be required to provide services such as formal nutritional or social service counseling to Medicaid clients? Will there be reimbursement for such expanded services?

A. According to the new prenatal care standards, all Medicaid prenatal care providers must provide or arrange for nutritional screening, counseling, and referral for care and should encourage and assist the pregnant woman in obtaining psychosocial services. If these services, other than nutritional screening and counseling, are provided by office based prenatal care providers during an E&M visit, the provider may bill the appropriate E&M visit code billed along with the HCPCS code **H1005 (prenatal care, at risk enhanced service package)**. H1005 will only pay when performed in conjunction with a medical visit or significant procedure visit. When an office based prenatal care practice provides nutritional screening and counseling during an E&M visit, the practitioner may bill an E&M visit or a significant procedure with the following CPT codes:

- 97802 (*Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes*)
- 97803 (*Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes*)

The maximum number of units that can be billed for these procedures is 2, which is equivalent to 30 minutes per visit. As with H1005, CPT codes 97802 and 97803 will only pay when billed in conjunction with a medical visit or significant procedure visit.

Q. When a woman has an initial prenatal care visit they are screened for nutrition. Do they have to be referred to the nutritionist for full evaluation?

A. Referral to a nutritionist for full evaluation is not required.

Q. Is there a copy of the DOH risk assessment screening form available and how will it be enforced?

A. The DOH is currently pilot testing a risk assessment form. When the form is finalized, it will be issued to all prenatal care providers in printed and electronic form. Enforcement of compliance has not yet been determined.

Q. Under the new prenatal care standards, is there a policy for the pregnant woman to be screened for depression by the physician and be referred for mental health services?

A. Yes. The policy is found in the new prenatal care standards Medicaid update article, Section D “Psychosocial Risk Assessment, Screening, Counseling and Referral for Care” (#4 “Depression”). The Medicaid update is available at: http://nyhealth.gov/health_care/Medicaid/program/update/main.htm

Q. Are there any updates or payment changes around coverage for prenatal/childbirth classes?

A. No, childbirth classes are not a Medicaid covered service and are not under consideration for coverage.

Q. Will Medicaid reimburse for the nutrition services for patients who are at high risk, e.g. gestational diabetes?

Medicaid covers nutritional services. Prenatal care providers may bill for these services using:

- *CPT-4 procedure code 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes)*
- *CPT-4 procedure code 97803 (Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes)*

These two procedure codes must be billed in conjunction with a medical visit or significant procedure visit to be reimbursed.

Q. Will Medicaid reimburse for services provided by a registered dietitian?

A. Registered dietitians cannot be enrolled in Medicaid as a qualified practitioner.

Q. How will care coordination, health education, psycho-social screening, and ante partum care be reimbursed?

A. Under APGs, when these services are provided in conjunction with an evaluation and management (E&M) visit or a significant procedure visit, they may be billed using HCPCS code H1005 (At-risk enhanced service package) along with the E&M visit. When the provider conducts a comprehensive risk assessment and completes the risk assessment form, the provider can bill the E&M visit along with HCPCS code H1000 (Prenatal care, at-risk assessment).

Q. Will prenatal vitamins be reimbursed under APGs?

A. Prenatal vitamins are covered by Medicaid as a pharmacy service. A line item payment is not available for prenatal vitamins under APGs. However, clinics may choose to provide the vitamins at their own expense or issue a fiscal order to be filled at a pharmacy.

Q. Will Medicaid pay for coverage of a woman's registration in a Lamaze program?

A. No, the registration fee for a Lamaze class is not reimbursable under Medicaid.

Q. What is the mechanism for getting Medicaid to cover transportation to a prenatal visit for a high risk pregnant woman?

A. A physician, physician's assistant, registered nurse practitioner or midwife must determine that transportation to the prenatal visit is medically necessary. In such instances, the local social services district will assist the prenatal clinic in arranging Medicaid coverage of medically necessary transportation to a prenatal visit.

Q. Can nutrition and or education services be ordered at a direct care visit and provided on a future date as with lab services when we are billing under APG's?

A. No, these services may only be billed on an APG claim when the patient has also seen a physician or other high level practitioner during the same visit and an evaluation and management or a significant procedure is billed. Nutrition and education services are not treated like ancillary lab or radiology service under the in APG payment methodology.

Q. Will prenatal care providers be reimbursed for breast feeding education?

A. No.

Q. Are prenatal care providers required to provide outreach for the prenatal care program?

A. In the new prenatal care standards, Section B "Access to Care", prenatal care providers are directed to provide or arrange for the provision of 24 hour/7 day week coverage. They must develop systems, or arrange for reminder/call backs to patients requiring continued or follow-up services and for visits requiring follow-up for abnormal test results. Outreach to patients to reschedule missed appointments is also required.

7. MEDICAID PRENATAL CARE PAYMENT POLICY FOR MEDICAL SERVICES

- Q. If patients are sent from a free standing D&TC to labor and delivery for observation, who bills for that service? Some are directly sent by the doctor the day of the visit and others are sent by an on-call doctor or go on their own.**
- A. The inpatient facility that is doing the labor and delivery observation bills Medicaid directly.
- Q. An on-site pharmacy is located in an Article 28 clinic. If a patient needs a medication not carried by the on-site pharmacy, will the patient be allowed to go to an outside pharmacy? If so, who will be responsible for payment?**
- A. The patient would be given a script to have filled by an outside pharmacy, and the pharmacy would bill Medicaid for payment.
- Q. Are HIV antiretroviral drugs also carved out of the APGs?**
- A. All HIV antiretroviral drugs are dispensed through pharmacies. The pharmacy then bills Medicaid fee-for-service.
- Q. Is there a limit to the number of perinatal home health care visits that can be done (as long as determined to be medically necessary)? Is there a limit to how far into the postpartum period that visits can be given?**
- A. There is no limit to the number of medically necessary home health care visits, and no limit as to how far into the postpartum period that such medically necessary visits can be given. All women enrolled in Medicaid are presumed eligible for one medically necessary postpartum home health care visit within the postpartum period of 60 days.
- Q. Can a perinatal home health care visit be ordered by a licensed midwife (or only by a physician)?**
- A. Home health visits require a physician's order.
- Q. Please elaborate on the future reimbursement for off-site and on-site sonograms.**
- A. Under APGs, the clinic is fiscally responsible for sonograms provided on-site and off-site. The exception is for the radiology professional component which can be billed fee-for-service by the radiologist.
- Q. If seasonal flu, H1N1 and pneumococcal vaccines are carved out of APG, how can providers bill for these vaccines after DT&C's are converted?**
- A. Seasonal flu, H1N1 and pneumococcal vaccines are carved out of APGs and should always be billed using the ordered ambulatory fee schedule.

Q. How are staple removals or wound checks billed using APGs?

A. These procedures are included in the follow-up care for the surgical procedure that was performed. No separate reimbursement is allowed.

Q. In the past, prenatal care clinics were required to transfer a woman to a specialist after 3 visits. Can a prenatal care clinic refer a woman to a perinatologist or other specialist for a consultation and continue to provide the woman with routine prenatal care; or is the clinic required to transfer the woman after the service is provided?

A. Yes, a prenatal clinic can refer a woman to a specialist and continue to keep her as a clinic patient for routine prenatal care. There is no limit on the number of specialist referrals that are medically necessary.

Q. Can more than one postpartum visit be provided if there is a medical need?

A. Yes, if the physician determines that the visit is medically necessary

Q. Will Medicaid continue to reimburse MOMS home visits at the current approved rate code 1604 or at the regular Medicaid home visit rate? Will it be mandatory that clients be seen at home?

A. Home visits are not reimbursed under Medicaid for MOMS providers.

Q. Can a pediatrician make a home health referral for newborn evaluation?

A. Yes, a pediatrician can make a referral for a newborn evaluation. Home health visits require a physician order, must be medically necessary, and must be ordered by the patient's attending physician and documented in the plan of treatment.

Q. Can providers bill for both mother and infant if comprehensive assessments are being completed on each one in separate time frames?

A. Generally, an initial post partum visit can only be billed once. However, visits for both mother and infant can be billed separately if there is a physician order and treatment plan for the mother and a separate order and treatment plan for the infant.

HIV Counseling/Testing

Q. How will clinics providing prenatal care services submit claims and be paid for HIV counseling and testing?

A. Rate codes 2961 (AIDS Clinic Therapeutic Visit), 2983 /1695(HIV Counseling and Testing), 3109 (HIV Counseling-No Testing) and 3111/1802 (Post Testing Counseling-Positive Result) are carved out of APGS. If a provider has been assigned these rate codes, the rate codes may be billed to Medicaid in addition to the APG rate code when both HIV counseling/testing as well as prenatal care services are provided to a patient during the same visit. All other medically necessary HIV services (other than those identified with the rate codes identified above) are reimbursable under APGs.

Laboratory/Radiology Ancillary Services

Q. If the new law eliminates the global fee, does that mean clinics are not required to pay for services to outside providers (such as labs)?

A. Under APGs, the payment to clinics includes payment for ancillary lab and radiology services. Clinics are responsible for reimbursement to providers of ancillary lab and radiology ancillary services for clinic patients.

Q. How will clinics providing prenatal care services submit claims and be paid for laboratory testing?

A. Ancillary laboratory tests (excluding laboratory tests that are carved out of APGs) ordered by hospital-based or free-standing (D&TC) clinics will be reimbursed in the APG payment to the ordering clinic. The clinic ordering the laboratory service is responsible for paying the provider of these laboratory services. The provider of the laboratory services must bill the ordering clinic and cannot submit a claim to Medicaid. Laboratory tests carved out of APGs are to be billed fee-for-service to Medicaid (see the following link for further information: http://www.nyhealth.gov/health_care/medicaid/rates/apg/index.htm). Facilities should not submit claims for ancillary laboratory services until the service has been completed and test results have been reported to the ordering provider. When the clinic submits an episode of care claim for the ancillary lab services, the claim can have different dates of service for the lab services and the E&M visit. The claim will pay on the line level.

Q. In an office based practice, how will providers bill for ultrasounds and lab services for prenatal Medicaid patients?

A. The provider should bill for these services fee-for-service to Medicaid using the physician fee schedule.

Q. Will APG payment be made for a (urine) pregnancy test when it is the only service provided and claimed for that visit?

A. A urine pregnancy test is carved out of APGs and can be billed fee-for-service to Medicaid when it is the only test performed.

Q. How will clinics providing prenatal care services submit claims, and be paid for genetic testing and what specific genetic screening tests does Medicaid reimburse for?

A. All genetic testing is carved out of APGs. Providers of these services should bill Medicaid fee-for-service using the laboratory fee schedule. The laboratory fee schedule is available online at:

<http://www.emedny.org/ProviderManuals/Laboratory/index.html>

Q. How will clinics providing prenatal care services submit claims and be paid for radiology services and ultrasounds?

A. As of February 1, 2010, the professional component of radiology services is carved-out of the APG payment to the hospital OPD and may be billed separately by the radiologist using the Medicaid fee schedule. This applies when a clinic patient receives radiology services from a clinic and the clinic is billing Medicaid under APGs for the patient encounter as well as those situations when a patient has been referred from another hospital outpatient department or free-standing clinic to a clinic and that clinic is billing the referring hospital/free-standing clinic for the radiology service (the referring hospital/free-standing clinic must bill for the radiology procedures on their Medicaid APG claim).

- *The radiologist should use the radiology fee schedule (physician component) for radiology procedures provided to patients referred by other hospitals or free-standing clinics.*
- *The facility that provides the radiology services should bill the referring hospital or free-standing clinic for the technical component.*
- *The referring hospital or free-standing clinic must include the radiology procedure in the APG claim for the visit in which the radiology procedure was prescribed.*

Note: The ancillary vendor may not bill the professional component of the radiology service if the hospital practitioner is planning to read and bill for this professional service. If the hospital plans to bill for the professional component of radiology service, the hospital should tell the ancillary vendor not to bill for the professional component of this service.

Q. Who bills for the ultrasound when a prenatal care clinic refers a patient to a physician specialist who contracts with the clinic?

A. The referring prenatal care clinic must bill Medicaid for the technical component of the ultrasound on their APG claim. The physician specialist bills Medicaid for the professional component of the ultrasound on a fee-for-service basis.

Q. What should a facility do if an ultrasound or laboratory test is ordered and the patient has never gone for the test, but the provider submitted a claim under APGs and receives payment?

A. Facilities should not submit claims for ancillary services until the service has been completed and reported to the ordering provider. If a claim has been submitted and paid prior to the facility receiving the results of the ordered services, the claim should be voided.

Q. How will providers performing lab/radiology services be reimbursed for these services?

A. Medicaid policy states that the provider performing the lab/radiology service cannot bill Medicaid. The clinic ordering these services must bill Medicaid and reimburse the provider of service.

Q. Are Level I drugs, labs, and radiology packaged into the medical visit or are they significant procedures?

A. All Level 1 pharmacotherapy, laboratory, and radiology procedures are packaged into the medical visit or significant procedure. Line level payments are not made for such services. The costs associated with the Level 1 procedures listed above are included in the facility payment for the medical visit or significant procedure.

Q. Are there exceptions to the APG ancillary billing policy?

A. There are four exceptions to the uniform application of the APG billing policy for ancillary laboratory and radiology services provided on behalf of clinic patients. They include the following:

- *Laboratory and radiology tests performed on behalf of Federally Qualified Health Centers that do not participate in the APG payment methodology;*
- *Procedure codes carved-out of APGs as specified in Section (e.g. Coumadin, Clozaril, lead screen, HIV viral load, virtual phenotype, blood factors, etc.);*
- *Procedure codes which may be carved-out of APGS (optional carve-outs) as specified in Section (e.g. pregnancy testing); and*
- *Laboratory and radiology services associated with specialty clinic rate codes carved-out of APGs as specified in Section since these are not “APG” visits.*

Additional detail on the above exceptions to the APG ancillary policy can be found in Section 4 “Physician Services” of the APG Provider Manual available online at: http://nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual

Q. Can a radiologist bill for the professional fee for reading an x-ray if he/she is not salaried by the facility?

A. Yes, regardless of whether the radiologist is salaried by the facility, the radiologist should bill the professional component to Medicaid using the physician fee schedule.

Q. If a clinic has a contract with a local hospital for referred labs and x-ray services and a patient chooses to go to a different location, what is the clinic’s liability?

A. The clinic is responsible for reimbursing the provider of the ordered testing even though there is no formal contract.

Q. How will clinics providing prenatal care services submit claims and be paid for lead screening?

A. Lead testing is carved out of the APG payment. Testing laboratories should bill for the service directly using the Medicaid fee schedule. Requirements for Medicaid reimbursement of point-of-care blood lead testing:

- Lead testing is a covered Medicaid service when the provider is following NYS Public Health Law and regulations for blood lead testing of children and pregnant women, and when otherwise clinically indicated.
- The provider must hold CLIA certification issued through the NYSDOH's Physician Office Laboratory Evaluation Program (POLEP), **OR** be a hospital off-site clinic or free-standing D&TC that is registered as a Limited Service Laboratory with the Clinical Laboratory Evaluation Program.
- A practitioner must be enrolled with Medicaid as a physician office laboratory (POL). A clinic must be enrolled for ordered ambulatory laboratory services.
- The provider's records must document the following to be entitled to reimbursement:
 - *operation of any CLIA-waived test device is in accordance with both the manufacturer's instructions (the package insert) and standards of laboratory practice as posted at <http://www.nyhealth.gov/environmental/lead>*
 - *proper procedures for collection of finger stick blood samples are followed to avoid contamination and otherwise ensure reliable results;*
 - *timely referral is made for confirmation of all blood lead specimens/patients with test results greater than or equal to 8 mcg/dL using a venous sample analyzed by a clinical laboratory that holds a NYS permit in toxicology-blood lead.*
 - *Lead testing can be provided in a POL, provided that it is performed by physicians, nurse practitioners, licensed midwives, or trained employees.*
 - *The provider must comply with requirements for reporting of blood lead test results to the NYSDOH, posted at <http://www.nyhealth.gov/environmental/lead>*

Q. How will an ultrasound be reimbursed when a patient is seen in a high risk clinic for her pregnancy and then sees the doctor?

A. Under APGs, the clinic is fiscally responsible for sonograms provided on-site and off-site. The exception is for the radiology professional component which can be billed fee-for-service by the radiologist.

Q. Can ultrasounds be billed separately if the service is provided on a different day than the clinic visit?

A. Under APGs, regardless of the date of service, the clinic is fiscally responsible for ultrasounds associated with a clinic visit, regardless of whether they are provided on-site and off-site. The exception is for the radiology professional component which can be billed fee-for-service by the radiologist.

Q. Some clinics have reported that they make appointments for their patients with contracted lab and radiology vendors. Can recipients be directed to use contracted vendors instead of being given their freedom of choice?

A. While hospital outpatient clinics and free-standing D&TCs may have contracts with lab and radiology providers, Medicaid patients, not enrolled in managed care, have the freedom to choose to receive lab or radiology services from any enrolled Medicaid provider.

Q. How will clinics providing prenatal care services submit claims and be paid for non- stress tests and fetal biophysical profiles?

A. CPT procedure codes for these services should be reported on the claim. These tests are considered to be significant procedures and will map to an APG for payment.

Immunizations

Q. How will clinics providing prenatal care services submit claims and be paid for immunizations?

A. Seasonal flu, H1N1 and pneumococcal flu vaccines are billed fee- for- service to Medicaid using the ordered ambulatory fee schedule.

- *All other immunizations should be billed using APGs, and the prenatal care clinic will get paid for the cost of the vaccine plus an administration fee.*
- *If the immunization is for a recipient under age 19, the immunization is covered under the VFC program. The prenatal care clinic can bill the vaccine procedure code as an ordered ambulatory service and append with the "SL" modifier.*

For additional flu vaccine information please review the October 2009 Special Edition of the Medicaid Update available at:

http://nyhealth.gov/health_care/medicaid/program/update/2009/index.htm.

Q. Is Depo-Provera covered by Medicaid? If not, how do clinics receive reimbursement for the drug and or administration?

A. The Depo-Provera injection (CPT-4 procedure code J1055) is covered by Medicaid. When Depo-Provera is administered by a doctor or another high level practitioner during an E&M visit, the clinic is reimbursed under APGs for the therapeutic injection and administration. When Depo-Provera is administered by RN or LPN (within their scope of practice) and no other services are provided during that patient encounter, Depo-Provera and its administration cost may be billed using the ordered ambulatory fee schedule. An E&M visit cannot be billed.

Q. How is Rhogam billed under APGs?

A. Rhogam is not considered a pharmaceutical. It is an immunoglobulin and cannot be directly billed to Medicaid as a pharmaceutical. Under APGs, if the lab work and administration of Rhogam is performed by a hospital outpatient clinic, the hospital outpatient clinic would bill the ordering clinic for reimbursement, and the ordering clinic would submit an APG claim when the tests and the administration of the Rhogam have been completed.

Q. If a small prenatal care clinic refers their patients, who require Rhogam, to a hospital based prenatal care clinic, does the hospital based clinic bill Medicaid directly for this service (labs, Rhogam, and administration)?

A. The hospital administering the Rhogam should bill Medicaid using the ordered ambulatory fee schedule. The CPT codes for Rhogam are: 90384, 90385, and 90386.

Q. Can a licensed midwife provide nutrition counseling?

A. A licensed midwife is qualified to be a prenatal care provider and can provide all mandated prenatal care services which include nutrition counseling.

Q. What should be done when a screening indicates a home visit is needed but staff is not available to provide the home visit?

A. The prenatal care clinic must make arrangements with a CHHA to provide the necessary prenatal or postpartum visit.

Q. If the doctor sees a patient in the clinic and then the patient is sent to labor and delivery for an evaluation and an ultrasound is done as part of the evaluation, who is responsible for paying for that sonogram if it was ordered by the physician evaluating the patient?

A. The inpatient facility that is doing the labor and delivery observation bills Medicaid directly.