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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 93 LCM-119

Date: September 10, 1993

Division: Health and Long
Term Care

TO: Local District Commissioners

SUBJECT: Implementation of Co-Payments for Medicaid Recipients
on November 1, 1993

ATTACHMENTS: 1. Dear Medicaid Recipient letter (On-line)
2. Medicaid Co-Payment Fact Sheet (On-line)
3. Medicaid Update Article (On-Line)
4. Dear Pharmacy Provider Letter (On-Line)

NOTE: This LCM is not a complete document as it is missing the Spanish translation of Attachment #2, the Medicaid Co-Payment Fact Sheet. This will be sent to you under separate cover.

This Local Commissioners Memorandum (LCM) is to inform you that on June 17, 1993, the United States Court of Appeals for the Second Circuit removed the restraining order which had prevented the Department from imposing co-payments on Medicaid recipients as required by Chapter 41 of the Laws of 1992 which amended Section 367-a(6) of Social Services law.

As you are aware, the Department had attempted to implement co-payments on June 1, 1992, and December 1, 1992. LCMs 92-LCM-73 and 92-LCM-157 respectively were issued to provide details of the new co-payment program. However, implementation of Medicaid co-payments was delayed at both times by the courts issuing temporary restraining orders. This LCM will provide a complete description of all necessary co-payment requirements including the services subject to co-payment and applicable exemptions.

Effective November 1, 1993, certain Medicaid recipients may be asked to contribute to the cost of some medical services/items. Notices are being sent out to all providers advising them of full implementation of recipient co-payments (Attachment #3 and #4). The attached Dear Medicaid Recipient letter explaining the new program requirements will be mailed by the Department in early October, 1993 to the heads of households in all Public Assistance and Medical Assistance Only cases determined eligible as of September 18, 1993 with an effective eligibility date of October 1, 1993 (Attachment #1). These are being provided to you for informational purposes only.

Effective September 20, 1993, local districts must distribute the attached Medicaid Co-Payment Fact Sheet (Attachment #2) with the application packet provided to all PA and MA Only applicants. Revised Client Booklets are being developed by the Department to include co-payment information and when you receive them, distribution of the fact sheet to new applicants will no longer be required. Additionally, local districts should note that co-payments are to be applied towards a recipient's monthly spenddown when determining financial eligibility for Medical Assistance. Recipients have been instructed to save all co-payment receipts (see Attachment #1) to verify the dollar amount which may be applied to reduce the spenddown.

Following are the major highlights of the co-payment program. Refer to the attached documents for further details on the program.

A. Co-payments will apply to the following services only:

- o Inpatient hospital services provided by Article 28 facilities, hospitals with dual certification (Article 28 and Article 31), and out of state hospitals;
- o Outpatient hospital and free-standing clinic;
- o Non-emergency/non-urgent visits to emergency rooms (ER);
- o Drugs (Exceptions: 1. psychotropic drugs, as defined by the Department, 2. family planning drugs, 3. FDA approved drugs for the treatment of TB);
- o Enteral and Parenteral formulae/supplies;
- o Medical/surgical supplies (except family planning items);
- o Laboratory services (except when provided by physicians who bill directly and are not licensed as a provider of laboratory services);
- o X-ray services (except when the service is provided by physicians).

B. Co-payment amounts are as follows:

<u>Service</u>	<u>Amount (\$)</u>
Inpatient Hospital	25.00 per stay upon discharge
Outpatient Hospital and Clinic	3.00 per visit
Non-emergency/Non-urgent ER Visits	3.00 per visit
Prescription Drugs, Generic	0.50 per prescription
Brand Name	2.00 per prescription
Psychotropic	NO CO-PAYMENT
Family Planning	NO CO-PAYMENT
TB Drugs	NO CO-PAYMENT
Nonprescription Drugs	0.50 per order
Enteral/Parenteral Formulae/Supplies	1.00 per order/prescription
Medical/Surgical Supplies	1.00 per order
Laboratory	0.50 per procedure code
X-ray	1.00 per procedure code

Note: From November 1, 1993 until March 31, 1994 there is a \$41 maximum per recipient for all co-payments. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments.

C. Recipients exempt from co-payment include the following:

- o Recipients under the age of twenty-one;
- o Pregnant women (this exemption continues for two months after the month in which the pregnancy ends);
- o Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- o Recipients enrolled in HMOs and Managed Care programs;
- o Residents of OMH and OMRDD certified community residences and recipients enrolled in an OMRDD Home and Community Based Services (HCBS) waiver program.

D. Exempt services include the following:

- o Emergency services;
- o Family planning services;
- o Psychotropic drugs (see attachment #4);
- o Tuberculosis Directly Observed Therapy;
- o FDA approved drugs used for the treatment of Tuberculosis (see attachment #4);

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- o Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services.

Note: There is no co-payment on physician, dental, home health, and personal care services.

Further Information

For further information on the co-payment program, please call 1-800-342-4100, ext. 3-5983. Electronic mail should be directed to Richard Nussbaum at User I.D. #DMA041.

Sue Kelly
Deputy Commissioner
Division of Health and Long Term Care

Dear Medicaid Recipient:

It is important that you read this letter to understand the following changes to Medicaid and that you keep this letter for future use.

Beginning November 1, 1993 most Medicaid recipients age 21 or older will be asked to pay for part of the cost of their medical care each time they see a Medicaid provider. This payment is called a co-payment or co-pay. From November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred. Co-payments were to begin June 1, 1992, based on a change to Section 367-a(6) of Social Services law, but were delayed because of a court order. However, the court has told us we can now ask for co-payments. The provider who sees you (such as a clinic or pharmacy) will ask for the co-payment.

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

There is a toll free telephone number that you can use to report providers who refuse to give you care because you are unable to pay the co-payment. The number is 1-800-541-2831 and can be called between 8:30 a.m. and 5:00 p.m. Monday through Friday.

There are a number of exemptions from co-payments. Please read this entire letter to see if you do not have to pay co-payments or if the services you need do not have co-payments.

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

1. INPATIENT HOSPITAL CARE - The co-payment for each hospital stay (if you have to stay one or more nights) is \$25. You may be charged only one co-payment for the entire hospital stay. You may be asked for this co-payment when you leave the hospital.
2. EMERGENCY ROOM VISITS - The co-payment for each non-emergency or non-urgent visit to an emergency room is \$3.00. If you get emergency or urgent care in the emergency room, you will not have to pay a co-payment. The emergency room will decide whether you are getting emergency or urgent care.

3. CLINIC VISITS - The co-payment for each visit to a clinic is \$3.00. Visits to clinics for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not have a co-payment.
4. PRESCRIPTION DRUGS - The co-payment for each new prescription and each refill for a brand-name drug is \$2.00. The co-payment for each new prescription and each refill for a generic drug is \$.50. There is no co-payment for certain drugs to treat mental illness or tuberculosis. Your pharmacist can tell you if there is a co-payment for the drug you need.
5. NONPRESCRIPTION DRUGS - The co-payment for each new order and each refill for a nonprescription (over-the-counter) drug is \$.50.
6. SICKROOM SUPPLIES - The co-payment for each new order and each refill for a sickroom supply is \$1.00. Sickroom supplies include ostomy bags, heating pads, bandages, gloves, vaporizers, syringes, etc.
7. LABORATORY SERVICES - The co-payment for each laboratory procedure billed by a laboratory to Medicaid is \$.50.
8. X-RAYS - The co-payment for each x-ray you get is \$1.00. If the x-ray is taken by your doctor in his/her office, there is no co-payment.

NOTE: There is no co-payment for services by private practicing physicians or dentists. There is also no co-payment for Home Health Services and Personal Care Services.

YOU DO NOT HAVE TO PAY THE CO-PAYMENT:

1. If you are unable to pay and you tell your provider that you are unable to pay.
2. If you are younger than 21 years of age.
3. If you are pregnant. If you are pregnant, have your doctor write a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.
4. If you are enrolled in a managed care program or a health maintenance organization (HMO). Your local social services office can tell you if you belong to a managed care program or HMO.
5. For care or services for an emergency. This is care given to you to treat a severe life-threatening or potentially disabling condition that needs immediate care.
6. For family planning services (birth control or fertility). This includes family planning drugs or supplies such as birth control pills or condoms.

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7. If you are a resident of a Nursing Facility or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
8. If you are a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payments.
9. If you are enrolled in a Comprehensive Medicaid Case Management Program (CMCM) or a Home and Community Based Services (HCBS) Waiver Program. These programs are associated with the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD). You have a case manager if you are in either of the programs. The case manager can help you if you have any questions.

From November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred. The New York State Department of Social Services will record all your co-payments and inform providers when you have met the maximum co-payment for that year. The Department will also send you a letter when the maximum co-payment is reached.

Save your co-payment receipts if you are eligible for Medicaid by spending part of your income toward medical care. The co-payments you pay will count towards your spenddown (overage) in the following month.

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

FAIR HEARINGS: See the attachment for your fair hearing rights. You do not have a right to a hearing if you are only complaining about the change in the law and do not like the co-payment program. You have a right to a fair hearing if you think we made a mistake about the date of your birth and you are not age 21 or older (your birth date is on your Common Benefit Identification Card) or we made a mistake about whether you are in a managed care program, HMO, or a resident of a Nursing Facility, or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), or a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities or enrolled in a Comprehensive Medicaid Case Management Program (CMCM) or a Home and Community Based Services (HCBS) waiver program. The hearing officer may decide that you did not have the right to a hearing if you are only complaining about the change in State law. Remember, if you can't afford the co-payments, you should tell this to the provider, and you will not be required to pay.

Sincerely,

Sue Kelly

MEDICAID CO-PAYMENT FACT SHEET

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

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

There is a toll free telephone number that you can use to report providers who refuse to give you care and tell you that it is because you are unable to pay the co-payment. The number is 1-800-541-2831 and can be called between 8:30 a.m. and 5:00 p.m. Monday through Friday.

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

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

1. INPATIENT HOSPITAL CARE - The co-payment for each hospital stay (if you have to stay one or more nights) is \$25. You may be asked for this co-payment when you leave the hospital.
2. EMERGENCY ROOM VISITS - The co-payment for each non-emergency or non-urgent visit to an emergency room is \$3.00. If you get emergency or urgent care in the emergency room, you will not have to pay a co-payment. The emergency room will decide whether you are getting emergency or urgent care.
3. CLINIC VISITS - The co-payment for each visit to a clinic is \$3.00. Visits to clinics for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not have a co-payment.
4. PRESCRIPTION DRUGS - The co-payment for each new prescription and each refill for a brand-name drug is \$2.00. The co-payment for each new prescription and each refill for a generic drug is \$.50. There is no co-payment for certain drugs to treat mental illness or tuberculosis. Your pharmacist can tell you if there is a co-payment for the drug you need.
5. NONPRESCRIPTION DRUGS - The co-payment for each new order and each refill for a nonprescription (over-the-counter) drug is \$.50.

6. SICKROOM SUPPLIES - The co-payment for each new order and each refill for a sickroom supply is \$1.00. Sickroom supplies include ostomy bags, heating pads, bandages, gloves, vaporizers, syringes, etc.
7. LABORATORY SERVICES - The co-payment for each laboratory procedure billed by a laboratory to Medicaid is \$.50.
8. X-RAYS - The co-payment for each x-ray you get is \$1.00. If the x-ray is taken by your doctor in his/her office, there is no co-payment.

NOTE: There is no co-payment for services by private practicing physicians or dentists. There is also no co-payment for Home Health Services and Personal Care Services.

YOU DO NOT HAVE TO PAY THE CO-PAYMENT:

1. If you are unable to pay and you tell your provider that you are unable to pay.
2. If you are younger than 21 years of age.
3. If you are pregnant. If you are pregnant, have your doctor write a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.
4. If you are enrolled in a managed care program or a health maintenance organization (HMO). Your local social services office can tell you if you belong to a managed care program or HMO.
5. For care or services for an emergency. This is care given to you to treat a severe life-threatening or potentially disabling condition that needs immediate care.
6. For family planning services (birth control or fertility). This includes family planning drugs or supplies such as birth control pills or condoms.
7. If you are a resident of a Nursing Facility or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
8. If you are a resident of a community based residential facility that is licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payments.
9. If you are enrolled in a Comprehensive Medicaid Case Management Program (CMCM) or a Home and Community Based Services (HCBS) Waiver Program. These programs are associated with the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD). You have a case manager if you are in either of the programs. The case manager can help you if you have any questions.

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From November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments. The New York State Department of Social Services will record all your co-payments and inform providers when you have met the maximum co-payment for that year. The Department will also send you a letter when the maximum co-payment is reached.

Save your co-payment receipts if you are eligible for Medicaid by spending part of your income toward medical care. The co-payments you pay will count towards your spenddown (overage) in the following month.

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

ARTICLE FOR DEFICIT REDUCTION PLAN
CO-PAYMENTS

The United States Court of Appeals for the Second Circuit has lifted the temporary restraining order that enjoined the Department from implementing co-payments. Therefore, the Department is proceeding with implementation of co-payments for Medicaid recipients on November 1, 1993. Although all of the co-payment requirements are described herein, the following are major changes from last year's May, 1992 Medicaid Update article which described co-payments:

- 1- Residents of community based residential facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities are exempt from co-payments;
- 2- Home Health Services are exempt from co-payment;
- 3- Pregnant women are exempted from co-payment for the duration of the pregnancy and through the second month after the end of the pregnancy;
- 4- Drugs used in the treatment of tuberculosis are exempt from co-payment;
- 5- The list of exempt psychiatric drugs has been expanded.

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 |CO-PAYMENT SPECIFICATIONS |
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PROVIDERS' OBLIGATIONS TO PROVIDE SERVICES (RECIPIENT'S INABILITY TO PAY):

The legislation enacting co-payments provides that a provider may not deny services to an eligible recipient based on the recipient's statement that he/she is unable to pay the co-payment amount. You cannot refuse to provide services to otherwise eligible recipients who indicate they cannot pay or are unable to pay the co-payment. Under circumstances in which a recipient is unable to pay the co-payment, the provider will be required to accept the reduced Medicaid payment as full payment. If you refuse to provide services, it is an unacceptable practice.

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

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

CO-PAYMENT MAXIMUM:

From November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred.

Providers must access EMEVS and enter co-payment information on the date of service for all recipients, regardless of whether recipients pay or do not pay the co-payment. Doing this will help ensure that EMEVS will accurately indicate when co-payments are no longer due from recipients and will not be deducted from claims.

Note: If a retroactive EMEVS inquiry indicates a co-payment is due, providers should not bill the recipient.

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|SERVICES WITH CO-PAYMENT REQUIREMENTS |
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1. INPATIENT HOSPITAL CO-PAYMENT:

Each inpatient hospital stay billed to the Medicaid Management Information System (MMIS) will have a \$25 co-payment deducted from the final payment amount calculated as due from Medicaid. If a Medicaid recipient is transferred to another inpatient facility for specialty or continuing care, a co-payment will be deducted only from the payment made to the facility which discharges the recipient from inpatient care to a non-inpatient level of care. If a recipient is discharged to return home and subsequently re-enters the same inpatient facility, co-payments will be deducted for both inpatient stays upon billing at discharge. The co-payment applies to all hospitals certified under Article 28 of Public Health Law. Hospitals with dual certification and hospitals located outside of New York State will be subject to the co-payment provisions for all inpatient care rendered to Medicaid recipients. Co-payments do not apply to psychiatric hospitals certified under Article 31 of the Public Health Law.

2. OUTPATIENT HOSPITAL AND EMERGENCY ROOM CO-PAYMENT:

Each outpatient hospital visit billed to the Medicaid Management Information System (MMIS) will have a \$3.00 co-payment deducted from the final payment amount calculated as due from Medicaid. Visits to hospital emergency rooms for non-emergency or non-urgent medical care will have a \$3.00 co-payment deducted from the final payment amount calculated as due from Medicaid. Emergency care and urgent care services are exempt from co-payment. Consult your MMIS provider manual for definitions of emergency and urgent care services.

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

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

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4. RADIOLOGY CO-PAYMENT:

Each radiology procedure code in the range 70000 through 79999 including procedures billed with modifiers will have a \$1.00 co-payment deducted from the final payment amount calculated as due from Medicaid. Co-payments do not apply to radiology procedures billed by practitioners.

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

- The co-payment amount is \$1.00 for each product (claim line) for a sickroom supply dispensed. Sickroom supplies are identified in sections 4.3 and 4.4 of the MMIS Pharmacy Provider Manual and in sections 4.1, and 4.3 of the MMIS DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual. Hearing aid dispensers should note that the co-payment applies to hearing aid batteries because they are considered sickroom supplies.

- The co-payment amount for enteral and parenteral formulae/supplies is \$1.00 per product (claim line). Enteral and parenteral formulae/supplies are identified in section 4.2 of the MMIS Pharmacy Provider Manual and the MMIS DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual.

- The co-payment amount is \$2.00 for each brand name (single source or innovator multiple source) prescription drug dispensed, \$.50 for each generic prescription drug dispensed and \$.50 for each nonprescription (OTC) drug dispensed.

6. CLINICAL LABORATORY CO-PAYMENT:

Each laboratory procedure billed by independent laboratories, hospital laboratories and ordered ambulatory laboratories will have a \$.50 co-payment deducted from the final payment amount calculated as due from Medicaid. Co-payments do not apply to laboratory procedures billed by practitioners for patients in their offices when these practitioners are not licensed and enrolled as laboratories.

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| EXEMPTIONS FROM CO-PAYMENTS |
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There are no special co-payment exemptions for recipients age 65 and older. The only co-payment exemptions are described in the following sections.

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| 1. EXEMPTIONS WHICH APPLY TO ALL PROVIDER TYPES |
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A. EMERGENCY SERVICES:

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

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- MMIS claiming instructions:

Outpatient hospitals, clinics, and ordered ambulatory providers must enter a "Y" for yes in the Emergency Related field on the Medicaid claim to identify the service as an emergency when submitting the claim to MMIS for payment.

Pharmacies and medical/surgical suppliers must enter the code "L" in the SA Excp Code field to identify an emergency when submitting the claim to MMIS for payment.

Inpatient hospitals must enter the emergency code in the Type (of admission) field to identify an emergency when submitting the claim to MMIS for payment.

B. FAMILY PLANNING SERVICES AND ITEMS:

Medical services, drugs and supplies provided for family planning purposes are exempt from co-payment.

- MMIS claiming instructions:

Inpatient hospitals must enter a "Y" for yes in the family planning area in the Special Program field to identify a family planning claim when family planning is the primary procedure when submitting the claim to MMIS for payment.

Outpatient hospitals, clinics, ordered ambulatory and laboratory providers must enter a "Y" for yes in the Family Planning field on the Medicaid claim to identify the service as a family planning service when submitting the claim to MMIS for payment.

Pharmacies and medical/surgical suppliers are NOT required to use a special code on the claim to identify family planning claims. Family planning drugs and supplies include products identified in the Provider Manuals under the headings of "Family Planning Products" as well as any prescription drug which is used for family planning purposes.

C. RECIPIENTS UNDER AGE 21:

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

D. PREGNANT RECIPIENTS:

Pregnant women are exempt from co-payments for the duration of the pregnancy and for the two full months following the month in which the pregnancy ends. Prenatal care providers should provide the pregnant recipient with a note verifying her condition and should instruct her to show it to other providers such as pharmacies or laboratories when obtaining supplies or services. Other providers treating the woman may use the note as verification of her

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condition. In lieu of a note, a provider may verify the pregnancy with visual evidence, by phone contact with the prenatal provider, by type of drug or supply ordered (such as prenatal vitamins), or by determining that the source of the prescription/order is a Prenatal Care Assistance Program, or an obstetrician.

- MMIS claiming instructions:

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

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

E. RECIPIENTS ENROLLED IN MANAGED CARE PROGRAMS AND COMPREHENSIVE MEDICAID CASE MANAGEMENT PROGRAMS (CMCM):

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

Terminal Response	Telephone Response	Alternate Access Code
"ELGIBLE PCP"	"ELIGIBLE PCP"	"06"
"ELIG CAPITATION GUARANTEE"	"ELIGIBLE CAPITATION GUARANTEE"	"05"
"ELIGIBLE PCP HR"	"PREPAID CAPITATION PLAN HOME RELIEF"	"114"
"GUARANTEE HR"	"GUARANTEE HOME RELIEF"	"115"

Recipients enrolled in a Comprehensive Medicaid Case Management Program are exempt from co-payments. Providers do not need to enter a special code on the claim to identify recipients who are in these programs. These recipients are identified on EMEVS by the following responses:

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Terminal Response	Telephone Response	Alternate Access Code	Meaning
"EXCP CD 35"	"EXCEPTION CODE 35"	"35"	Designates an individual who receives CMCM
"EXCP CD 50"	"EXCEPTION CODE 50"	"50"	Designates an individual who is eligible to receive CONNECT-Only/Perinatal Family Services
"EXCP CD 51"	"EXCEPTION CODE 51"	"51"	Designates an individual who receives CMCM under the CONNECT Program

F. ICF/DD AND NURSING FACILITY RESIDENTS:

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

Terminal response	Telephone response	Alternate Access Code	Meaning
EXCP CD 38"	"EXCEPTION CODE 38"	"38"	Designates an individual who is a resident of an ICF/DD

G. RESIDENTS OF OMH AND OMRDD CERTIFIED COMMUNITY RESIDENCES AND RECIPIENTS ENROLLED IN AN OMRDD HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAM:

1. Residents of OMH and OMRDD Certified Community Residences

Recipients who are residents in Community Residences certified by the Office Of Mental Health or the Office of Mental Retardation and Developmental Disabilities are exempt from co-payments. Each month the Community Residence will give recipients a letter to show providers which certifies that they live in a community residence and are exempt from co-payments. This letter will serve as verification that a recipient is exempt from co-payments.

2. Recipients enrolled in an OMRDD Home and Community Based Services (HCBS) Waiver Program

Recipients enrolled in the OMRDD HCBS Waiver Program are exempt from co-payments. These recipients will, on a monthly basis, be provided a letter which certifies they are enrolled in an HCBS Waiver Program and are exempt from co-payments. This letter will serve as verification that a recipient is exempt from co-payments.

MMIS claiming instructions:

Inpatient hospitals must enter an "R" in the Special Federal Funding Project area in the Special Program field (field 156) on the inpatient claim form to identify residents of Community Residences or recipients enrolled in an HCBS Waiver Program when submitting a claim to MMIS for payment.

Providers other than inpatient hospitals must use the code "Z8" in the Recipient Other Insurance Code field on the claim to identify residents of Community Residences and recipients enrolled in an OMRDD HCBS Waiver Program.

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|                                     |
|                               NOTE |
|  THERE IS NO CO-PAYMENT ON PRIVATE PRACTICING PHYSICIAN SERVICES, HOME |
|  HEALTH SERVICES, PERSONAL CARE SERVICES, OR LONG TERM HOME HEALTH CARE |
|  SERVICES                         |
|                                     |
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| 2. EXEMPTIONS FROM CO-PAYMENTS WHICH APPLY |
| ONLY TO SPECIFIC TYPES OF PROVIDERS:      |
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A. EMERGENCY ROOM VISITS FOR EMERGENCY OR URGENT CARE:

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

MMIS claiming instructions:

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

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

MMTP, MENTAL HEALTH CLINIC VISITS, MENTAL RETARDATION CLINIC VISITS, ALCOHOL AND SUBSTANCE ABUSE CLINIC VISITS:

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

+-----+
| Specialty codes EXEMPT from co-payment: |
+-----+

- 300 - Physical Therapy - Long Term Maintenance
- 301 - Occupational Therapy - Long Term Maintenance
- 302 - Speech Therapy - Long Term Maintenance
- 304 - Medical Rehabilitation - Long Term Maintenance
- 309 - Medically Supervised Substance Abuse
- 310 - OMH Adult Clinic (State Operated)
- 311 - OMH Child Clinic (State Operated)
- 312 - OMH Continuing Day Treatment (State Operated)
- 313 - OMH Partial Hospitalization (State Operated)
- 314 - OMH Intensive Psychiatric Rehabilitative Treatment
- 315 - OMH Adult Clinic
- 316 - OMH Child Clinic
- 317 - OMH Continuing Day Treatment
- 318 - OMH Partial Hospitalization
- 319 - OMH Intensive Psychiatric Rehabilitative Treatment
- 320 - Clozapine Case Manager
- 322 - OMH Comprehensive Outpatient Program (COPS) Clinic
- 323 - OMH Comprehensive Outpatient Program (COPS) Continuing Day Treatment
- 922 - Methadone Maintenance Treatment Program
- 945 - Psychiatry, Individual
- 946 - Psychiatry, Group
- 947 - Psychiatry, Half Day Care
- 948 - Psychiatry, Full Day Care
- 949 - Alcoholism Treatment Program
- 963 - Child Psychiatry
- 964 - Psychiatry, General
- 971 - Mental Health Clinic Treatment, State Operated
- 972 - Mental Health Day Treatment, State Operated
- 973 - Mental Health Continuing Treatment, State Operated
- 974 - Mental Health Clinic Treatment
- 975 - Mental Health Day Treatment
- 976 - Mental Health Continuing Treatment
- 977 - Mental Retardation/Developmental Disabilities Clinic Treatment, State Operated
- 979 - Mental Retardation/Development Disabilities Clinic Treatment
- 981 - Diagnostic and Research Clinic Mental Retardation, State Operated
- 983 - Specialty Clinic, Mental Retardation
- 984 - Alcoholism Clinic Treatment, State Operated

- 985 - Alcoholism Day Rehabilitation, State Operated
- 986 - Alcoholism Clinic Treatment
- 987 - Alcoholism Day Rehabilitation
- 988 - Comprehensive Alcoholism Care
- 989 - Alcoholism Detoxification (Demonstration Project)

+-----+
| Rate codes EXEMPT from co-payment: |
+-----+

- 4060 - OMH Day Treatment, Full Day
- 4061 - OMH Day Treatment, Half Day
- 4062 - OMH Day Treatment, Brief
- 4063 - OMH Day Treatment, Home Visit
- 4064 - OMH Day Treatment, Crisis Service
- 4065 - OMH Day Treatment, Pre-admission Full Day
- 4066 - OMH Day Treatment, Collateral
- 4067 - OMH Day Treatment, Pre-admission Half Day
- 4068 - OMH / OMR Mental Health Day Treatment, Collateral Visit
Brief
- 4070 - OMH Continuing Treatment, Full Day
- 4071 - OMH Continuing Treatment, Half Day
- 4072 - OMH Continuing Treatment, Brief
- 4073 - OMH Continuing Treatment, Home Visit
- 4074 - OMH Continuing Treatment, Crisis Service
- 4075 - OMH Continuing Treatment, Pre-admission Full Day
- 4076 - OMH Continuing Treatment, Collateral Visit
- 4077 - OMH Continuing Treatment, Pre-admission Half Day
- 4160 - OMR/DD Day, State Operated, Full Day
- 4161 - OMR/DD Day, State Operated, Half Day
- 4162 - OMR/DD Day, State Operated, Home
- 4163 - OMR/DD Day, State Operated, Intake
- 4164 - OMR/DD Day, State Operated, Diagnosis and Evaluation
- 4165 - OMR/DD Day, State Operated, Collateral
- 4166 - OMR/DD Day, State Operated, Full Day Subchapter A
- 4167 - OMR/DD Day, State Operated, Half Day Subchapter A
- 4170 - OMR/DD Day Treatment, Full Day
- 4171 - OMR/DD Day Treatment, Half Day
- 4172 - OMR/DD Day Treatment, Home
- 4173 - OMR/DD Day Treatment, Intake
- 4174 - OMR/DD Day Treatment, Diagnosis and Evaluation
- 4175 - OMR/DD Day Treatment, Collateral
- 4176 - OMR/DD Day Treatment, Full Day Subchapter A
- 4177 - OMR/DD Day Treatment, Half Day Subchapter A
- 5312 - TB Directly Observed Therapy NYC Level 1
- 5313 - TB Directly Observed Therapy NYC Level 2
- 5314 - TB Directly Observed Therapy NYC Level 3
- 5315 - TB Directly Observed Therapy NYC Level 4
- 5316 - TB Directly Observed Therapy NYC Level 5
- 5317 - TB Directly Observed Therapy ROS Level 1
- 5318 - TB Directly Observed Therapy ROS Level 2
- 5319 - TB Directly Observed Therapy ROS Level 3
- 5320 - TB Directly Observed Therapy ROS Level 4
- 5321 - TB Directly Observed Therapy ROS Level 5

C. PHARMACY SPECIFIC EXEMPTIONS:

PSYCHOTROPIC DRUGS EXEMPT FROM
CO-PAYMENT REQUIREMENTS EFFECTIVE NOVEMBER 1, 1993

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

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

DRUGS FDA INDICATED FOR THE TREATMENT OF TUBERCULOSIS
WHICH ARE EXEMPT FROM CO-PAYMENT REQUIREMENTS EFFECTIVE NOVEMBER 1, 1993

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

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

INFORMATION AND INSTRUCTIONS FOR ENTERING CO-PAY DATA ON EMEVS
(RETAIN FOR FUTURE REFERENCE)

In order to accommodate the entry and accumulation of recipient co-payment data on EMEVS, new co-payment prompts have been added for terminal users. New input data fields (alternate access users) have been added to the EMEVS system as well. Alternate access (PC, CPU, RJE) providers have been sent revised layouts for the input and output data streams. The additional prompt for the telephone users will be added prior to implementation.

- o The new prompts and alternate access field names are as follows:

TERMINAL	- "COPAY TYPE/UNT 1"
ALTERNATE ACCESS	- "CO-PAYMENT TYPE #1"
	"CO-PAYMENT UNITS #1"
ARU/TELEPHONE	- "ENTER FIRST CO-PAYMENT TYPE"
	"ENTER CO-PAYMENT UNITS"

- o The "COPAY" or "CO-PAYMENT TYPE" refers to the type of co-payment service required and "UNT or Units" refers to the number of co-payment services.
- o On the VeriFone Tranz 330 terminal and telephone, the new prompt will appear after the referring provider number.
- o The new co-payment entry fields have been designed to allow you to enter a recipient's co-payment data for the service you are rendering. You may bypass any co-pay prompt by pressing enter on the terminal or # on the telephone. Alternate access providers can "bypass" by defaulting with spaces.
- o The co-pay information can be entered through either an eligibility (Tran 2) or service authorization (Tran 1) transaction. If both transactions are necessary for the same claim, only enter the co-pay data on one transaction.

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- Co-pay information should be entered on a current day basis. Except for inpatient hospital services, co-pay entries are to be made on the actual date of service. Hospitals entering inpatient services must wait until the patient is being discharged and enter the co-pay at that time, using the discharge date as the date of service.
- Please note that while the terminal prompt is used for the examples in the contents of this article, the descriptions, definitions and co-pay information apply to all methods of EMEVS access.
- The "COPAY TYPE" prompt is an alpha entry with the valid letter designations:

- A = Inpatient Hospital
- B = Emergency Room - non-emergency, non-urgent
- C = Clinic
- D = Prescription Drugs - brand name
- E = Prescription Drugs - generic
- F = Non-Prescription Drugs - (OTC)
- G = Sickroom Supplies/Enteral and Parenteral formulae/supplies
- H = Laboratory
- I = X-ray
- X = No CO-PAY

- The letter designation entered in the "COPAY TYPE" field depends upon what type of service you are rendering.
- The "UNT 1" field is a numeric field which allows for entry of a single or two digit number. Co-pay dollar amounts are NOT to be entered in this field or on the EMEVS. The number of units being rendered/dispensed is the only valid entry for this field. The correct dollar value will be determined by EMEVS based on co-pay type and units of services.
- The entry in the "UNT" field depends upon the number of service units you are rendering. For example: One lab test procedure performed once would equate to 1 unit. A pharmacy would enter the number of new and/or refill prescriptions in the unit field, not the number of tablets, capsules, etc.
- Terminal users will see the message "BAD COPAY ENTRY" if anything other than an alpha character in the COPAY TYPE field and/or numeric digit in the UNT field is entered. Receiving this message will prohibit the next prompt from appearing. To proceed, the correct alpha/numeric format needs to be entered.

Once the correct format is entered, if an invalid "COPAY TYPE" (any letter other than A-I or X) or invalid unit (blank or zero with codes A-I) is entered, you will receive the denial response "REENTER COPAY". For alternate access providers, a new denial reason code, 126, will be added to Table 2 to reflect this response.

- Some examples of valid entries in the "COPAY TYPE/UNT 1" field are:

- 1) A Hospital rendering one inpatient stay for a recipient would enter A1.
- 2) A Pharmacy filling two brand name prescriptions for a recipient would enter D2.
- 3) A Lab performing 10 laboratory test procedures for a recipient would enter H10.

- o If your initial co-pay entry format is valid, you will be prompted to a "COPAY TYPE/UNT 2", then a "COPAY TYPE/UNT 3" and finally "COPAY TYPE/UNT 4". The additional co-pay prompts would be used by a provider who is rendering more than one "COPAY TYPE" (letter designations A-I) of service. A maximum of 4 "COPAY TYPES" can be entered.

For example: A Pharmacy supplying one brand name prescription; three generic prescriptions and two non-prescription drug orders would enter D1 at the "COPAY TYPE/UNT 1" prompt; E3 at the "COPAY TYPE/UNT 2" prompt and F2 at the "COPAY TYPE/UNT 3" prompt.

If you are rendering just one "COPAY TYPE" of service and only require one co-pay entry, press enter at the "COPAY/TYPE UNT 2" prompt and the "COPAY TYPE/UNT 3 and 4" prompts will be bypassed. You may bypass any co-pay prompt by pressing enter on the terminal.

- o The "COPAY TYPE" letter designation X was designed to allow providers who know that a recipient is co-pay exempt (emergency service, pregnancy, managed care, etc.) to enter co-pay data. A provider choosing to enter co-pay data for an exempt recipient would enter X0 (zero). This is the only time that a zero can be entered as a valid entry in the unit field. A zero is a valid UNT entry with the letter X only if X0 is entered. If X0 is entered, the second co-pay prompt will be returned but should be bypassed. An entry of X in any one of the four co-pay prompts, will negate any other co-pay type entries made in the same transaction, since X means the recipient is exempt.

Bypassing the first (and all) co-pay prompt, has the same affect as entering an X. The recipient's co-pay file will be bypassed with either option.

- o If a co-pay response is to be returned, the response will appear before any service authorization data.
- o Except for recipients under age 21, no special co-pay messages will be returned for co-pay exempt recipients. The existing eligibility messages will be returned.

If a recipient is under age 21, a "NO COPAY REQD" response will be returned if a valid entry (letter A-I) was made at the co-pay prompt. If nothing is entered at the co-pay prompt or if the letter X is entered, no response will be returned if the recipient is under age 21. Alternate access providers will see this response added as new reason code 128.

- No other co-pay responses will be returned until the recipient has met the co-pay annual maximum responsibility.

Once the \$100.00 co-pay maximum (or \$41 co-pay maximum for the time period November 1, 1993 through March 31, 1994) has been accumulated on the recipient's file on EMEVS, the response "COPAY MET MMDDYY" (month, day, year) will be returned. The date returned in the response will be the date of the EMEVS inquiry which brought the co-pay amount over the annual maximum. If you receive this response, you should not collect the co-pay from the recipient for services on or after that date. Alternate access providers will see this response added as new reason code 127.

Once the "COPAY MET MMDDYY" response is received for a recipient for the current co-pay year, no further co-pay entries are required until the new co-pay year begins.

- For the co-pay year beginning November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred. If a recipient met their maximum \$41 co-pay responsibility on 1/1/94, that recipient would not be responsible for another co-pay payment until 4/1/94. The response received on an inquiry would be "COPAY MET 1/1/94". If a recipient met their maximum \$100.00 co-pay responsibility on 8/1/94, that recipient would not be responsible for another co-pay payment until 4/1/95. The response received on an inquiry would be "COPAY MET 8/1/94".
- Once a recipient has met their co-pay responsibility for the co-pay year, a letter will be generated which informs the recipient that their co-pay maximum responsibility has been met for that co-pay year. The letter will also verify the date of co-pay maximization and may be presented to you as proof that no co-pay is required as of that date.
- A cancel transaction (Tran 4) will not remove a co-pay entry, lessen the accumulated co-pay amounts or change the date that the co-pay maximum was reached. A cancel will result in the reversal of entered data (as currently exists) except for co-pay entered data. Making a co-pay entry results in the updating to the recipient's master record with the EMEVS determined dollar amount which cannot be deleted through a cancel transaction or corrected via review function.
- If your eligibility (Tran 2) or service authorization (Tran 1) results in one of the existing ineligible responses (Not MA Eligible, Recipient Not on File, Invalid Provider Number, etc.) and no further information is returned to you, the co-pay entry made during this transaction is invalid and will not update the recipient's co-pay master record.

Dear Pharmacy Provider:

This is to inform you that the United States Court of Appeals for the Second Circuit removed the restraining order which had prevented the Department from imposing co-payments on Medicaid recipients. Therefore, the Department is proceeding with implementation of co-payment requirements.

Medicaid co-payments will begin on November 1, 1993. Prescription drugs, nonprescription drugs, and sickroom supplies dispensed on or after November 1, 1993 will be subject to the co-payment requirements described in this letter. Note: Changes have been made to the co-payment program since our last notice. Among the changes is a revised list of exempt psychotropic drugs and a new list of exempt drugs used to treat tuberculosis. Also, from November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred.

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

The legislation includes the provision that the provider may not deny services to an eligible recipient based on the recipient's statement that he/she is unable to pay the co-payment amount. You cannot refuse to provide services to otherwise eligible recipients who indicate they cannot pay or are unable to pay the co-payment. Under circumstances in which a recipient is unable to pay the co-payment, the provider will be required to accept the reduced Medicaid payment as full payment. If you refuse to provide services, it is an unacceptable practice.

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

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

+-----+
| CO-PAYMENT SPECIFICATIONS |
+-----+

PRESCRIPTION DRUGS

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

NONPRESCRIPTION DRUGS

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

ENTERAL AND PARENTERAL FORMULAE/SUPPLIES

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

SICKROOM SUPPLIES

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

Notes:

1. Any single source or innovator multiple source drug as determined by the Department. For purposes of co-payments, a single source drug or innovator multiple source drug will be considered a brand name drug and be subject to a \$2.00 co-payment even if it is dispensed for a generic (non-DAW) prescription.
2. Consult attached list.
3. As defined in Sections 2.2.2 and 4.5 of the MMIS Pharmacy Manual
4. Oral contraceptive drugs and Clomid.
5. Emergency services are services which are provided after the sudden onset of a medical condition which manifests itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Enter code "L" in the SA Excp Code field on the claim to identify an emergency when submitting a claim to MMIS for payment.

RECIPIENTS WHO ARE EXEMPT FROM CO-PAYMENT

1. Recipients Under Age 21:

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

2. Pregnant Recipients:

Pregnant women are exempt from co-payments during the duration of their pregnancy, and for the two full months following the month in which the pregnancy ends. Prenatal care providers should provide the pregnant recipient with a note verifying her condition and should instruct her to show it to other providers such as pharmacies or laboratories when obtaining supplies or services. Other providers treating the woman may use the note as verification of her condition. In lieu of a note, a provider may verify the pregnancy with visual evidence, by phone contact with the prenatal provider, by type of drug or supply ordered (such as prenatal vitamins), or by determining that the source of the prescription/order is a Prenatal Care Assistance Program, or an obstetrician. Use the code "Z9" in the Recipient Other Insurance Code field on the claim to identify a pregnant recipient when submitting a claim to MMIS.

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

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

Terminal Response	Telephone Response	Alternate Access Code
"ELGIBLE PCP"	"ELIGIBLE PCP"	"06"
"ELIG CAPITATION GUARANTEE"	"ELIGIBLE CAPITATION GUARANTEE"	"05"
"ELIGIBLE PCP HR"	"PREPAID CAPITATION PLAN HOME RELIEF"	"114"
"GUARANTEE HR"	"GUARANTEE HOME RELIEF"	"115"

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

B. Comprehensive Medicaid Case Management Programs - Recipients enrolled in a Comprehensive Medicaid Case Management Program are exempt from co-payments. These recipients are identified on EMEVS by the following responses:

Terminal Response	Telephone Response	Alternate Access Code	Meaning
"EXCP CD 35"	"EXCEPTION CODE 35"	"35"	Designates an individual who receives CMCM
"EXCP CD 50"	"EXCEPTION CODE 50"	"50"	Designates an individual who is eligible to receive CONNECT-Only/Perinatal Family Services
"EXCP CD 51"	"EXCEPTION CODE 51"	"51"	Designates an individual who receives CMCM under the CONNECT Program

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

4. ICF/DD and Nursing Facility Residents:

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

Terminal Response	Telephone Response	Alternate Access Code	Meaning
EXCP CD 38"	"EXCEPTION CODE 38"	"38"	Designates an individual who is a resident of an ICF/DD

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

NOTE: Residents of Adult Homes are not exempt from co-payments.

5. Residents of OMH and OMRDD Certified Community Residences and Recipients Enrolled in an OMRDD Home and Community Based Services (HCBS) Waiver Program:

Recipients who are residents in Community Residences certified by the Office Of Mental Health or the Office of Mental Retardation and Developmental Disabilities or are enrolled in an OMRDD certified Home and Community Based Services (HCBS) Waiver Program are exempt from co-payments. Each month the Community Residence or the HCBS Program will give recipients

Attachment #4, Page 5

a letter to show providers which certifies that they live in a community residence and are exempt from co-payment. This letter will serve as verification that a recipient is exempt from co-payment. Use the code "Z8" in the Recipient Other Insurance Code field on the claim to identify residents of Community Residences and recipients participating in the HCBS Program.

6. Co-Payment Maximum:

From November 1, 1993 until March 31, 1994, there is a \$41 maximum per recipient for all co-payments incurred. Then, for each 12 months beginning April 1, 1994, there will be a \$100 maximum per recipient for all co-payments incurred.

Providers must access EMEVS and enter co-payment information on the date of service for all recipients, regardless of whether recipients pay or do not pay the co-payment. Doing this will help ensure that EMEVS will accurately indicate when co-payments are no longer due from recipients and will not be deducted from claims. Further instructions on how providers may access EMEVS to enter and obtain co-payment information will follow in a future issue of The Medicaid Update.

Sincerely,

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

Attachments

PSYCHOTROPIC DRUGS EXEMPT FROM
CO-PAYMENT REQUIREMENTS EFFECTIVE NOVEMBER 1, 1993

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

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

Attachment #4, Page 7

DRUGS FDA INDICATED FOR THE TREATMENT OF TUBERCULOSIS WHICH ARE EXEMPT
FROM CO-PAYMENT REQUIREMENTS EFFECTIVE NOVEMBER 1, 1993

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

Aminosalicylate Sodium (Para-Aminosalicylate Sodium)

Capreomycin Sulfate

Cycloserine

Ethambutol

Ethionamide

Isoniazid

Pyrazinamide

Rifampin

Streptomycin