



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany,

New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 29, 2005

Dear Commissioner:

The intent of this letter is to clarify documentation requirements for presumptive eligibility for a pregnant woman. Since the September 8, 2004 teleconference on presumptive eligibility, some districts are uncertain about which situations require documentation, particularly of identity and residence.

As described at 18 NYCRR 360-3.7(d), presumptive eligibility begins with the date on which a qualified provider determines, on the basis of preliminary information, that the household income of the woman does not exceed the applicable eligibility income level under the State Plan, which is 200% of the Federal Poverty Level. Submission of the Medicaid Presumptive Eligibility for Pregnant Woman Screening Checklist (LDSS-4150), which serves as medical verification of pregnancy, and the woman's verbal statement of her household income, is the sole requirement for establishing presumptive eligibility. Verification of identity and residence is not required. Please note that this policy applies only to presumptive eligibility. When you determine full eligibility, all documentation requirements must be met.

The only instance in which the pregnant applicant seeking presumptive eligibility should document identity and residence is when a county is taking a courtesy application; i.e., the woman's primary residence is in a different district of fiscal responsibility. Please refer to "Presumptive Eligibility for Pregnant Women and Residency," addressed in GIS 97 MA/028, dated 11/07/97.

Please contact your upstate local district liaison at (518) 474-8216, or the New York City office at (212) 417-4500 if you have any questions or concerns.

Sincerely,

Betty Rice, Director
Division of Consumer and Local District Relations
Office of Medicaid Management

Physician Reimbursement for Intrauterine Devices

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Medicaid reimbursement for intrauterine devices (IUDs) furnished by practitioners to their patients is based on the acquisition cost to the practitioner.

Effective for dates of service on or after April 1, 2005, an invoice is not required to be submitted with the claim. Therefore, an IUD can now be billed electronically.

Practitioners are required to keep auditable records of the actual itemized invoice cost of the IUD.

The CPT codes for IUDs are:

- J7300; and
- J7302.

If you have any questions, please contact the Bureau of Policy Development and Agency Relations at (518) 473-2160.

Documentation Requirements: Presumptive Eligibility for Pregnant Women

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This article clarifies documentation requirements for *Presumptive Eligibility for Pregnant Women*.

Presumptive eligibility begins with the date on which a qualified provider determines, on the basis of preliminary information, that the household income of the pregnant woman does not exceed 200% of the Federal Poverty Level.

The sole requirement for establishing presumptive eligibility is:

Submission of the Medicaid Presumptive Eligibility for Pregnant Woman Screening Checklist (LDSS-4150), which serves as medical verification of pregnancy, and the woman's verbal statement of her household income.

Verification of identity and residence is not required!

This policy applies only to presumptive eligibility. When local departments of social services determine full eligibility, all documentation requirements must be met.

The only instance in which the pregnant applicant seeking presumptive eligibility should document identity and residence is when a local department of social services is taking a courtesy application; i.e., the woman's primary residence is different from the county in which presumptive eligibility is being determined by a qualified provider.

If you have any questions or concerns, please call (518) 486-6562.

DSS-4357EL

WGIUPD

GIS 97 MA/028

GENERAL INFORMATION SYSTEM
DIVISION: Office of Medicaid Management

11/07/97

PAGE 1

TO: Local District Commissioners, MA Directors

FROM: Ann Clemency Kohler, Director, Office of Medicaid Management

SUBJECT: Presumptive Eligibility for Pregnant Women and Residency

EFFECTIVE DATE:

CONTACT PERSON: Shari Niedbalec, (518)473-5531

This is a clarification concerning the documentation requirements for identity and residency of pregnant women, particularly students attending college in a county other than their county of residence.

The Department is sending presumptive eligibility providers a letter with instructions to obtain documentation of identity and residence when the pregnant woman is applying for presumptive eligibility in a county other than their county of permanent residence. The applicant's driver's license, student identification card or other credible evidence is sufficient verification of identity and permanent residence. The providers will be instructed to send this documentation with the presumptive eligibility checklist and application to the pregnant woman's county of permanent residence/district of fiscal responsibility. An exception to this policy exists when the local social services office in the county where the pregnant woman is applying agrees to take a courtesy application. The courtesy application, including the presumptive eligibility checklist and documentation, will then be forwarded to the county of fiscal responsibility.

TO: Commissioners of Social Services, MA Directors

FROM: Richard T. Cody, Deputy Commissioner, Division of Health & Long Term Care

SUBJECT: Revisions to Regulations 360-2.2(f)(1) and 360-2.4(a)(1)

EFFECTIVE DATE: May 1, 1996

CONTACT PERSON: Priscilla Smith at 1-800-343-8859, ext. 3-5532 or New York Representative at (212) 383-2512

This is to inform Social Services Districts of changes to Department Regulations 360-2.2(f)(1) AND 360-2.4(a)(1) that are effective MAY 1, 1996.

The revision to regulation 360-2.2(F)(1) eliminates the 5 day timeframe requirement in which Social Services districts currently have to conduct a personal interview. There is still a personal interview requirement before making any decision concerning an applicant/recipient's eligibility for Medical Assistance (MA), but districts are no longer required to do the interview within 5 working days of application. Please note that agreements which districts have with PCAPS or other providers to complete initial processing of MA applications for pregnant women and/or young children at outreach sites are not impacted by this change. The interview by the provider at the outreach site meets the face-to-face interview requirements.

The revision to regulation 360-2.4(a)(1) changes the timeframe Social Services districts are allowed to determine an applicant's eligibility for MA from 30 days to 45 days. However, the timeframes to determine eligibility for pregnant women and young children and eligibility based on disability status or a separate determination (Rosenberg), remain unchanged.

Any questions should be directed to Priscilla Smith at 1-800-343-8859, extension 3-5532, or your New York City representative at (212) 383-2512.

Qualified Providers

Qualified Providers may be...

- PCAPs
- LDOHs
- Public Health Nursing Services
- Article 28s – Hospitals or D & T's
- Certified Home Health Agencies

New Training Material

- Cost effective
- Updates to material made easily
- Available statewide
- Responsibility for training no longer the role of LDSS

Use of the Modules

- Staff new to Presumptive Eligibility for Pregnant Women
 - View modules sequentially
- Staff familiar with the process
 - May view modules individually for review or as a refresher

Module 1: Overview of Presumptive Eligibility for Pregnant Women

- Glossary of Terms and Acronyms
- Steps in Presumptive Eligibility Process

Module 2: Completing the Screening Checklist

- Part A:
 - Introduction of Screening Checklist
 - Discussion of each section of the Screening Checklist
- Part B
 - Describes the Two Benefit Packages for Presumptive Eligibility
 - Practice Scenarios

Module 3: Medicaid Application

- Part A
 - Introduces Case Processing Checklist
 - Access NY (ANY) application
 - Reviews each section
 - Identifies who may apply on ANY
 - Identifies eligibility programs available through ANY

Module 3: Medicaid Application

- **Part B**
 - Practice Scenario
 - Growing UP Healthy (GUP) application
 - Reviews each section
 - Identifies who may apply on GUP
 - Identifies eligibility programs available through GUP
 - Determination Letter and Welcome Letter for Presumptive Eligibility

Module 3: Medicaid Application

- Practice Scenarios

Module 4: Special Populations and Documentation

- **Part A:**
 - Special Populations

- **Part B**
 - Documentation Requirements for Pregnant Woman
 - Next Steps
 - Practice Scenarios

Module 5: Expanded Eligibility and Coverage for Infants and Other Family Members

- **Part A**
 - Expanded Eligibility for Pregnant Woman
 - PW who are currently covered by FHPlus
- **Part B**
 - Coverage for Infants
 - Family Planning Extension Program
 - Coverage for Other Family Members

Questions?

- QPs can contact their LDSS liaison or the SDOH with any questions
- Questions about the web page or problems accessing the modules should be sent through the “tech support” link on the web site.

Determining the most current version

- Modules will be updated periodically to ensure that the most current, correct information is available
- Date of last update is included in module title
 - For example, Overview of the Presumptive Eligibility Process (January 2006)

**Documentation for PE
for Identity & Residency**

- GIS 97 MA/028
- Commissioner letter dated 3/20/05
- May 2005 Medicaid Update

**ELIGIBILITY CRITERIA FOR
CAH I & II**

- child is under 18 years of age
- child is determined physically disabled according to standards in the Social Security Act
- child is ineligible for Medicaid due to the parents' excess income and/or resources
- child is Medicaid eligible when parents' income and/or resources are not counted

**ELIGIBILITY CRITERIA FOR
CAH I & II**

- child can be cared for at home safely and at no greater cost than in the appropriate facility
- institutional stay requirement of 30 consecutive days

**HOME & COMMUNITY BASED
SERVICES WAIVER
FOR DEVELOPMENTALLY DISABLED
CHILDREN**

- Care at Home III (for intermediate care facility)
 - Capacity = 200
 - Monthly Expenditure Cap = \$9,000
- Care at Home IV (for intermediate care facility)
 - Capacity = 200
 - Monthly Expenditure Cap = \$9,000

**HOME & COMMUNITY BASED
SERVICES WAIVER
FOR DEVELOPMENTALLY DISABLED
CHILDREN**

- Care at Home V (intermediate care facility)
 - Capacity = 200*
 - Monthly Expenditure Cap = \$9,000

**HOME & COMMUNITY BASED
SERVICES WAIVER
FOR DEVELOPMENTALLY DISABLED
CHILDREN**

- The Center for Medicare and Medicaid Services (CMS) approved the Department of Health and the Office of Mental Retardation and Development Disability (OMRDD) request to add an additional 100 slots (making the capacity 200). The 100 new slots are effective March 1, 2005.
- These three waivers (CAH III, IV and VI) are administered by the Department of Health (DOH) and the Office of Mental Retardation and Development Disability (OMRDD).

**ELIGIBILITY CRITERIA FOR
CAH VII & VIII**

- child is under 18 years of age
- child is determined physically disabled according to standards in the Social Security Act
- child is Medicaid eligible when parents' income and/or resources are counted
- child can be cared for at home safely and at no greater cost than in the appropriate facility
- institutional stay requirement of 30 consecutive days

**HOME & COMMUNITY BASED SERVICES
WAIVER FOR PHYSICALLY DISABLED
CHILDREN & DEVELOPMENTALLY
DISABLED CHILDREN**

- Care at Home I (nursing facility level of care)
 - Capacity = 600
 - Monthly Expenditure Cap = \$9,000
- Care at Home II (hospital level of care with technology dependence)
 - Capacity = 400
 - Monthly Expenditure Cap = \$14,500

**HOME & COMMUNITY BASED SERVICES
WAIVER FOR PHYSICALLY DISABLED
CHILDREN & DEVELOPMENTALLY
DISABLED CHILDREN**

- Care at Home VII (nursing facility level of care Medicaid eligible)
 - Capacity = 100
 - Monthly Expenditure Cap = \$9,000
- Care at Home VIII (hospital level of care technology dependent Medicaid eligible)
 - Capacity = 100
 - Monthly Expenditure Cap = \$14,500

Conditions & Concerns

- Asthma
- Diabetes
- Nutrition
- Oral health
- Immunizations
- Lead poisoning

Conditions & Concerns

- HIV-AIDS
- Mental and developmental health
- Chemical dependency
- Special needs of adolescents
- Special needs and requirements for foster care youth

**EPSDT/CTHP Program
LDSS Responsibilities**

- Network with other local agencies serving children such as WIC and HeadStart to coordinate services offered by each
- The LDSS have submitted plans to our office describing how these functions are fulfilled in their county

**EPSDT/CTHP Program
LDSS Responsibilities**

- Conduct outreach and inform families with children about their CTHP benefits, whether fee-for-service or managed care, and the advantages of preventive health care
- Offer assistance in locating Medicaid providers, arranging transportation, or scheduling appointments
