

**NEW YORK STATE
MEDICAID PROGRAM**

**INPATIENT
POLICY GUIDELINES**

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Section I - Requirements for Participation in Medicaid

Among other services, a [hospital](#) must:

- ↗ provide diagnostic and therapeutic services for medical diagnosis, treatment and care of sick and injured persons;
- ↗ have laboratory and radiology services and organized departments of medicine and surgery;
- ↗ have an organized medical staff which may include in addition to doctors of medicine, doctors of osteopathy and dentistry;
- ↗ have rules, by-laws, and regulations which outline standards of medical care and services rendered by the medical staff;
- ↗ maintain medical records for each patient;
- ↗ require that every patient be under the care of a medical staff member;
- ↗ provide 24 hour patient services;
- ↗ have, in effect, a quality assurance program which meets all Federal statute regulations and is not limited to New York State Department of Health (NYSDOH) regulation 405.6 "Quality Assurance", available online at <http://www.health.ny.gov/nysdoh/phforum/nycrr10.htm>;
- ↗ have, in effect, an agreement with a home health agency for referral and transfer of patients to home health agency care when such service should be appropriate to meet the patient's needs.

Inpatient hospital services may be provided in public, incorporated (non-profit) or proprietary hospitals which meet the criteria as defined in [Section IV - Definitions](#), and:

- ↗ possess valid operating certificates issued in accordance with the provisions of Article 28 of the Public Health Law;
- ↗ are qualified to participate under Title 18 of the Federal Social Security Act or are determined to meet the requirements for such participation;
- ↗ have, in effect, hospital utilization review plans applicable to all patients; and
- ↗ meet all applicable provisions of Federal and State law and regulation.

Emergency hospital services may be provided in a hospital which does not currently meet Title 18 requirements when such services are necessary to prevent the death or serious impairment of the health of an individual and when the threat to life or health necessitates the use of the most accessible hospital available.

An individual hospitalized under such circumstances must, however, be transferred to a Title 18 participating hospital as soon as the transfer would not be medically hazardous for the individual.

Inpatient Care Provided Outside of New York State

Medicaid beneficiaries should obtain medical care and services from qualified providers located in New York State. Provision of medical care and services provided out-of-state is subject to the New York State Medicaid rules, regulations, policies, procedures, and rates applicable to in-state providers.

For beneficiaries obtaining services through the NYS Office of Mental Health, the New York State Office for People With Developmental Disabilities, NYS Office of Mental Retardation and Developmental Disabilities, the NYS Office of Addiction Services and Supports, NYS Office of Alcohol and Substance Abuse Services, the NYS Office of Long Term Care and/or the NYS Office of Children and Family Services, concurrence from those agencies may be required for care, services and placement out of state and provider enrollment.

Payment

Effective for discharges occurring on and after December 1, 2009, for inpatient hospital services, rates of payment for out-of-state providers shall be as follows:

- (1) The weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield; and
- (2) The weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the upstate region of New York State shall apply with regard to all other out-of-state providers.

The downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

See Title 10 NYCRR 86-1.33: <https://regs.health.ny.gov/content/section-86-133-out-state-providers>

Single Case Agreement (SCA)

A Single Case Agreement (SCA) is not required when an out-of-state provider accepts the applicable New York State fee-for-service Medicaid payment. If the Department determines that an out-of-state (OOS) provider is providing inpatient services which are not available within New York State, the Department may

negotiate payment rates and conditions with the provider; but prior approval is still required for services provided by such out-of-state providers.

SCA requests are submitted in written letter format from the member's in-state requesting physician and also include the completion of the [Request for Enhanced Rate for Out-of-State Medical Treatment form](#) and associated documentation including a listing of in-state hospitals/facilities contacted and reasons why in-state admission could not be arranged. Requests provided by the proposed OOS facility, rather than the member's case manager or in-state physician, will not be accepted.

The OOS hospital or provider will be notified verbally and in writing of the outcome of the review (approved or denied) of the enhanced rate for OOS treatment request. If the request is long-term, approval will be granted in 30-day increments. Length of approval will be determined by the Department based on services provided and estimated time to complete treatment.

Additional Requirements for Out-of-State Inpatient Services Providers

In addition to initially completing the Referral Form for Prior approval – OOS Medical Treatment, providers of inpatient services will need to schedule regular treatment team meetings at a frequency determined by the Department, to include NYSDOH Medicaid staff and any applicable staff from other NYS agencies (such as OMH, OPWDD, etc.). Monthly reports are also required prior to extensions being granted and must include the following information:

- Current Treatment Plan, including goals and achievements
- Current Discharge Plan
- Any new diagnoses, interim progress notes, consults and pertinent test results.

Medicaid Members with Medicare Primary

Providers must follow Medicare rules for care and services provided to Medicaid members who also have Medicare as their primary source of coverage. Medicare approved care and services provided to Medicare primary Medicaid members do not require prior approval from NYS Medicaid

Submissions: Fax prior approval requests to: (518) 402-3253 or send via email to: FFSOOS@health.ny.gov.

Questions? For questions related to out of state hospital referrals, contact the Bureau of Medical Review at 1-800-342-3005 option 4 or by email at FFSOOS@health.ny.gov

Providers

Out-of-State providers must enroll in the New York State Medicaid Program in order to be reimbursed by the Program. Only providers in the United States, Canada, Puerto Rico, Guam, the United States Virgin Islands and American Samoa are eligible for enrollment in the New York State Medicaid Program. Enrollment contact information is available in the **Information for All Providers - Inquiry Manual** at:

<http://www.emedny.org/ProviderManuals/AllProviders/index.aspx>.

Reporting Births via Electronic Birth Certificate

Within five business days of live birth to a woman in receipt of Medicaid or Family Health Plus, the hospital must report the birth to the DOH. This requirement is met by reporting the birth via the existing *Electronic Birth Certificate* (EBC).

The birth registrar should indicate the code for Medicaid in one of the payor fields which will allow the NYSDOH to review the birth information and, if appropriate, create Medicaid eligibility for the infant.

Determinations of Eligibility

Certain State regulations require hospitals and all-approved Medicaid providers to conduct a Medicaid eligibility verification clearance on each person who presents himself as a Medicaid patient in order to determine Medicaid eligibility status and medical coverage.

For an individual who has been determined to be eligible for Medicaid prior to hospitalization and who presents, upon admission, a Common Benefit Identification Card (CBIC) or a Temporary Medicaid Authorization, the hospital is responsible for taking reasonable steps to insure that:

- the individual is presenting a valid CBIC or letter,
- the bearer of the card/letter is who he claims to be, and
- the CBIC/letter indicates he is eligible for inpatient care on the date(s) of service.

For more information, please consult the [Information for All Providers, General Policy Manual](#) online at:

<http://www.emedny.org/ProviderManuals/AllProviders/index.aspx>.

For a patient who has not been determined eligible for Medicaid at the time of his admission but who wishes to apply for Medicaid in order to cover the hospitalization, a completed Medicaid application and required documentation

must be submitted to the recipient's local department of social services (LDSS).

For the appropriate LDSS office, please consult [Information for All Providers, Inquiry](#) online at:

<http://www.emedny.org/ProviderManuals/AllProviders/index.aspx>.

Medicaid eligibility can be retroactively determined for the three-month period prior to the month of application. The application must be submitted to the LDSS within three months following the month of the patient's admission to allow for retroactive Medicaid coverage for inpatient hospital care from the date of admission.

For patients between 21 and 65 years of age who reasonably appear to be medically disabled for a minimum period of 12 months, the hospital or physician should submit to the LDSS a *Medical Report for Determination of Disability* (Form DSS-486T).

Submission of this form in a timely manner will facilitate the determination of Medicaid eligibility. The LDSS will make a determination regarding the individual's eligibility and then notify the hospital and the patient of the determination.

Eligible with Surplus

A surplus ("spend-down") is the amount for which a Medicaid client is financially responsible before Medicaid will cover the client's healthcare.

If the LDSS determines that the patient is eligible with a surplus, that patient will be eligible for Medicaid coverage of appropriate care, supplies and services (inpatient and outpatient) when the patient has incurred or paid an amount of medical bills equal to their monthly surplus (excess income) amount for six months.

The patient is financially responsible for the amount of the surplus. The hospital may bill Medicaid for the amount of the remaining care in accordance with established Medicaid rates.

In some cases, the total hospital bill will be less than the patient's surplus. In such instances, after any third party insurances have paid, the hospital is to bill the patient for the remaining total amount and then notify the LDSS of the amount of the bill and the date(s) of service.

Enrollment of Newborns into Medicaid

Newborns born to women receiving Medicaid or Family Health Plus (FHPlus) on the date of birth are automatically Medicaid-eligible for one year.

Chapter 412 of the Laws of 1999 mandates that the NYSDOH, or its designee:

- enroll into the Medicaid Program infants born to women who are receiving Medicaid,

- ↗ assign a client identification number (CIN), and
- ↗ issue an active Medicaid identification card as soon as possible, but no later than ten (10) business days from the notification of the birth by the hospital.

If the mother is enrolled in a Medicaid Managed Care plan, the newborn will be enrolled in the same plan from the date of birth. Women who are in receipt of FHPlus at the time they give birth are treated in the same manner as women in receipt of Medicaid for purposes of hospital reporting and the infant's Medicaid eligibility.

Providers must not bill Medicaid fee-for-service, but rather must bill the Managed Care plan for the infant's hospital stay.

- ↗ If the mother's FHPlus plan also participates in Medicaid Managed Care, the newborn will be automatically enrolled in that Medicaid Managed Care plan.
- ↗ If the mother's FHPlus plan does not participate in Medicaid Managed Care, the mother will be asked to select a Medicaid Managed Care plan for the unborn child if she resides in a mandatory county.

If the mother does not have her unborn child pre-enrolled, the automated newborn enrollment process will put the infant in fee-for-service Medicaid and she may choose a Medicaid Managed Care plan for the newborn thereafter.

- ↗ If the mother resides in a voluntary county and her FHPlus plan does not participate in Medicaid Managed Care, the automated newborn enrollment process will put the infant in fee-for-service Medicaid and she may choose a Medicaid Managed Care plan or Medicaid fee-for-service for the newborn thereafter.
- ↗ The only exceptions to the automatic enrollment of a newborn into the same Managed Care plan as the mother are:
 - when a baby is born weighing less than 1200 grams (2 lbs. 10 oz.), or
 - a newborn under age six months is determined eligible for the SSI-related category, or
 - the mother is enrolled in certain special needs for partial capitation plans.

The child may subsequently be disenrolled to fee-for-service Medicaid, or be transferred to another health plan at the mother's request.

Questions regarding FHPlus or Medicaid eligibility for newborns should be referred to the toll-free Newborn Helpline at:

(877) 463-7680.

Mother Enrolled In Medicaid Managed Care or Family Health Plus

Hospitals must determine the newborn's Managed Care status by checking the mother's status on the electronic Medicaid eligibility verification system (MEVS). The hospital must check:

- ↗ Medicaid eligibility status;
- ↗ Medical coverage – Eligible Prepaid Capitation Plan (PCP) or FHPlus and an Insurance Code indicate enrollment in Managed Care or FHPlus plan and the specific Managed Care or FHPlus provider; and
- ↗ Benefit coverage codes to determine whether the patient has 'inpatient hospital' (letter 'A') and other relevant coverage included in the Managed Care benefit package.

It is possible that a pregnant managed care enrollee may present herself at an out-of-network hospital and need to be admitted for delivery. In this case, that hospital must notify the Managed Care plan promptly and bill the Managed Care plan for the newborn's and mother's inpatient costs associated with the birth.

The hospital should not bill the Medicaid Program; rather, Managed Care plans will reimburse the hospital at the Medicaid rate or at another rate if agreed to between the Managed Care plan and the hospital. If a hospital bill seMedNY and is paid, the State will recover the erroneous payment.

The Managed Care plan may not deny inpatient hospital costs if billing or notification is not timely except as otherwise provided by contractual agreement between the plan and the hospital.

Providers must continue to determine whether the newborn and/or mother is enrolled in a Managed Care plan. If either is enrolled and the service to be provided is a covered service by the Managed Care plan, the provider should contact the plan before rendering service, except in an emergency.

Hospitals must report live births to women in receipt of Medicaid or FHPlus to DOH, or its designee, within five business days of birth.

Hospitals may face a financial penalty if they fail to report within the established timeframes.

Hospitals must notify the mother, in writing upon discharge, that her newborn is deemed to be enrolled in the Medicaid Program and that she may access care, services, and supplies available under Medicaid for her baby, provided that she was in receipt of Medicaid or FHPlus at the time of the birth. The letter must indicate that the child is eligible to obtain Medicaid services even without a CIN or common benefit identification card.

Questions regarding Medicaid Managed Care should be referred to the Office of Managed Care at:

(518) 486-9015

or via email to omcmail@health.ny.gov.

Choice of Physician on the Medical Staff

A Medicaid patient must be given the right to choose a qualified physician on the medical staff of the hospital regardless of the type of bed accommodation assigned to him. However, if the patient has been referred for hospitalization by the emergency room or the hospital's outpatient department, the physician providing inpatient services may be selected by the hospital to assure continuity of care.

Record Keeping Requirements

Hospitals must meet the general Medicaid record-keeping requirements outlined in the [Information for All Providers - General Policy Manual](#) and in the State Regulations, as well as Medicare requirements established in accordance with Title 18 of the Social Security Act.

Additionally, hospitals must maintain adequate, complete and up-to-date medical records containing the information necessary to make required determinations of Medicaid coverage.

Hospital utilization review, quality assurance and improvement activities must provide for the identification of individual patients by means which assure confidentiality.

Section II – Inpatient Services

Medicaid patients are provided a full range of necessary diagnostic, palliative, and therapeutic inpatient hospital care, including but not limited to surgical, medical, nursing, radiological, laboratory, and rehabilitative services.

Inpatient Admissions

Medicaid generally follows Medicare's Two-Midnight Rule for inpatient admission decisions, which deems inpatient admission appropriate when the patient is expected to need hospital care for at least two midnights, ensuring that admission is medically necessary and that care cannot be provided in an outpatient setting.

For an inpatient admission order to be valid, it must be signed by a physician directly involved in the patient's care before admission. This involvement must be documented with signed notes showing the physician examined the patient, contributed to the care plan, and engaged in medical decision-making. The order must be completed by a qualified physician or practitioner (the "ordering practitioner") who:

- Holds admitting privileges at the specific hospital, and
- Is familiar with the patient's condition, treatment plan, and hospital needs at the time of admission.

The admission decision should be based on a comprehensive assessment, supported by documentation that reflects the need for inpatient care, such as continuous monitoring or intensive treatment. If the anticipated stay is less than two midnights, observation status should be considered, as it applies when the patient's needs are expected to resolve within a shorter timeframe and do not warrant inpatient admission.

Exceptions to the Two-Midnight Rule:

Certain circumstances may justify inpatient admission even if the patient does not meet the two-midnight rule. These exceptions include:

- Departure Against Medical Advice (AMA),
- Rapid clinical improvement,
- Transfer to another facility, and
- Patient death.

Where the admitting physician expects a patient to require hospital care for only a limited period that does not cross two midnights, an inpatient admission may be appropriate for payment under NYS Medicaid where the clinical judgment of the admitting physician and medical record support the determination. The decision of the physician should be based on the complexity of medical factors effecting the patient including patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record.

*Additional information can be found in the January 2025 Medicaid Update titled *Inpatient Admission and Observation Policy for Medicaid Providers*

https://www.health.ny.gov/health_care/medicaid/program/update/2025/no01_2025-01.htm#inpatient

Hospitals with Approved Residency

- ↗ A patient must be assigned to a member of a medical staff, who shall be the personal attending physician to the individual and assume professional responsibility for his care.
- ↗ Proper follow-up care after discharge, when the personal attending physician does not continue out-of-hospital care, must be given in the outpatient department by:
 - the personal attending physician;
 - members of the service or department which was responsible for the inpatient care; or,
 - if appropriate, members of another service or department; or
 - by a physician who, prior to the hospital admission, had been designated as the physician responsible for the care of the patient in the outpatient department.
- ↗ The patient must be referred to his/her own physician if medically feasible.
- ↗ In any specialty, physicians on the hospital staff must be organized as a group, firm, or service which is the same for inpatient and outpatient services.
- ↗ Personal and identifiable services must be given by the attending physician or the resident with oversight by the attending physician to the Medicaid patient, including:
 - review of the patient's history and physical examination, and
 - personal examination of the patient within a reasonable period after admission;
 - confirmation or revision of the diagnosis; determination of the course of treatment to be followed;
 - assurance that any supervision needed by interns and residents was furnished; and frequent review of the patient's progress.
- ↗ Personal and identifiable services provided to a patient by the attending physician must be identified in the patient's medical record; as well as evidence of ongoing supervision and oversight by the attending physician.
- ↗ Surgical residents must have personal supervision by the attending physician.

- ↗ The medical staff shall, based on written criteria, recommend privileges that are specific to treatments/procedures for each individual in such program prior to delivery of patient care services.

Psychiatric Care

Article 28 hospitals which admit patients in emergencies for immediate care, observation and treatment under Section 9.39 of the Mental Hygiene Law must be approved for such services by the Office of Mental Health.

Psychiatric Hospitals

For hospital care in institutions or facilities primarily or exclusively for treatment of the mentally ill, Medicaid reimbursement is available only for individuals under 21 years of age or over 65 years of age.

In the case of a person who attains the age of 21 during the course of hospitalization, reimbursement for hospital services may continue until that person reaches the age of 22.

Induced Termination of Pregnancy

Performance of induced terminations of pregnancy must conform to all applicable requirements set forth in regulations of the NYSDOH.

Except in cases of medical or surgical emergencies, no pregnancy may be terminated in an emergency room.

The Medicaid Program covers abortions which **have been determined to be medically necessary by the attending physician**. Social Services Law 365-a specifies the types of medically necessary care, including medically necessary abortions, which may be provided under the Medicaid Program.

Medically necessary services are those:

"...necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his/her capacity for normal activity or threaten some significant handicap and which are furnished to an eligible person in accordance with this title and the regulations of the Department."

Medicaid also relies on the language from the federal Supreme Court decision *Doe V. Bolton*, to further refine the definition for medically necessary abortions.

Doe v. Bolton held that the determination that an abortion is medically necessary "is a professional judgment that may be exercised in the light of all factors - physical, emotional, psychological, familial and the woman's age - relevant to the well-being of the patient. All these factors may relate to health."

The doctor makes the determination of medical necessity and so indicates on the claim.

Although Medicaid covers only medically necessary abortions, payment is made for both medically necessary and elective abortions provided to New York City patients.

Sterilization Requirements

Medical family planning services include sterilizations.

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering a client permanently incapable of reproducing.

In addition to provision of information at the initial counseling session, the physician who performs the sterilization must discuss the information below with the patient shortly before the procedure, usually during the pre-operative examination.

Medicaid reimbursement is available for sterilization only if the following requirements are met:

Informed Consent

The person who obtains consent (i.e., nurse practitioner or physician) for the sterilization procedure must offer to answer any questions the patient may have concerning the procedure, provide a copy of the *Medicaid Sterilization Consent Form (DSS-3134)* and provide verbally all of the following information or advice to the individual to be sterilized.

- ↗ The patient is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the patient might be otherwise entitled;
- ↗ Available alternative methods of family planning and birth control;
- ↗ The sterilization procedure is considered to be irreversible;
- ↗ Specific information about the sterilization procedure to be performed;
- ↗ Description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- ↗ A full description of the benefits or advantages that may be expected as a result of the sterilization; and
- ↗ The sterilization will not be performed for at least 30 days except under the circumstances specified below under "Waiver of the 30-Day Waiting Period."

Informed consent may **not** be obtained while the patient to be sterilized is:

- ↗ in labor or childbirth;
- ↗ seeking to obtain or obtaining an abortion; or

- ↗ under the influence of alcohol or other substances that affect the patient's state of awareness.

Waiting Period

The patient to be sterilized must have voluntarily given informed consent not less than 30 days or more than 180 days prior to sterilization.

When computing the number of days in the waiting period, the day the patient signs the form is not to be included.

The only exceptions to the 30-day waiting period are in the cases of:

- ↗ premature delivery when the sterilization was scheduled for the expected delivery date or
- ↗ emergency abdominal surgery.

In both cases, informed consent must have been given at least 30 days before the intended date of sterilization.

Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, as long as 72 hours have passed between the original signing of the informed consent and the sterilization procedure.

Minimum Age

The patient to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.

Mental Competence

The patient must not be a [mentally incompetent individual](#).

Institutionalized Individual

The patient to be sterilized must not be an [institutionalized individual](#).

Foreign Languages

An interpreter must be provided if the patient to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

Persons With Disabilities

Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind or otherwise disabled patients.

Presence of Witness

The presence of a witness is optional when informed consent is obtained, except in New York City (NYC) when the presence of a witness of the patient's choice is mandated by NYC Local Law No. 37 of 1977.

Sterilization Consent Form

A copy of the *New York State Sterilization Consent Form (DSS-3134)* must be given to the patient to be sterilized and completed copies must be submitted with all surgeon, anesthesiologist and facility claims for sterilizations.

The physician who performs the sterilization must sign the *Sterilization Consent Form* after the procedure has been performed, certifying that all Federal requirements have been met.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed *DSS-3134* in their files.

To obtain the *DSS-3134* form at no charge in English and/or Spanish, write to:

New York State Department of Health
Office of Health Insurance Programs
Governor Nelson A. Rockefeller Empire State Plaza
Corning Tower, Room 2029
Albany, New York 12237
Re: *DSS-3134 Form*

There is no order form to complete.

Your request should be on official letterhead and include the provider's name, address and the quantity of forms needed.

New York City

New York City (NYC) Local Law No. 37 of 1977 establishes guidelines to insure informed consent for sterilizations performed in New York City.

Conformance to the NYC Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in NYC.

Any questions relating to NYC Local Law No. 37 of 1977 should be directed to the following office:

Maternal, Infant & Reproductive Health Program
NYC Department of Health
125 Worth Street
New York, New York 10013
(212) 442-1740

Reaffirmation Statement (NYC Only)

A statement signed by the patient upon admission for sterilization, acknowledging again the consequences of sterilization and his/her desire to be sterilized, is mandatory within the jurisdiction of NYC.

Hysterectomies

Federal regulations prohibit Medicaid reimbursement for hysterectomies which are:

- ↗ performed solely for the purpose of rendering the patient incapable of reproducing; or,
- ↗ if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomies are covered by Medicaid if the patient is informed verbally and in writing prior to surgery that the hysterectomy will make her permanently incapable of reproducing.

The patient or her representative must sign Part I of the *Acknowledgement of Receipt of Hysterectomy Information Form (DSS-3113)*.

The requirement for the patient's signature on Form *DSS-3113* can be waived if:

- ↗ the woman was sterile prior to the hysterectomy;
- ↗ the hysterectomy was performed in a life-threatening emergency in which prior acknowledgement was not possible;
- ↗ the woman was not a Medicaid patient at the time the hysterectomy was performed but subsequently applied for Medicaid and was determined to qualify for Medicaid payment of medical bills incurred before her application.

For Medicaid payment to be made in these cases, the surgeon who performs the hysterectomy must certify in writing that one of the conditions existed and state the cause of sterility or nature of the emergency.

For example, a surgeon may note that the woman was postmenopausal or that she was admitted to the hospital through the emergency room, needed medical attention immediately and was unable to respond to the information concerning the acknowledgement agreement;

In cases involving retroactive eligibility, payment may be made if the surgeon certifies in writing that the woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions noted above was met.

Laboratory Services: Reimbursement Policy

Medicaid payment regulations at Title 18 NYCRR 505.7(g)(7) state that *no payment will be made on a fee-for-service basis for laboratory services when the cost of providing such services has been included in the Medicaid rate of payment for the provider of the patient care.*

Such providers include Article 28 hospitals (including hospital out-patient clinics) and free standing diagnostic and treatment centers.

Billing on a fee-for-service basis for tests already included in a facility's rate structure is considered to be a duplicate payment and, as such, will be recouped by Medicaid.

When a lab enters into an agreement or arrangement with a facility, the agreement must include the use of a system of internal controls to allow determination of whether services are billable to Medicaid or billable back to the Article 28 facility.

There are situations where one laboratory must refer specialized testing for inpatient, clinic, or ambulatory surgery patients to another lab.

In these cases, the lab making the referral must identify hospital-based patients so that the testing lab knows which services are not to be billed to Medicaid.

Finally, audits of laboratories have found that the ordering identification numbers on claims do not match those on the fiscal order forms. There have been situations where only one ordering provider identification number is indicated for all claims submitted by a laboratory.

This practice is incorrect and claims submitted in this manner may be disallowed on audit.

For proper billing procedures, please refer to the billing information section of the Laboratory Provider Manual online at

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

Outside Care: Reimbursement Policy

When an original admitting hospital sends a Medicaid inpatient to another hospital for purposes of obtaining a diagnostic or therapeutic service not available in the admitting hospital, the original admitting hospital is responsible for the provision of those services.

Neither hospital may bill the Medicaid Program separately for these services.

The Medicaid payment for inpatient care is considered to include all procedures and services regardless of where they were performed.

The original hospital is responsible for reimbursing all other hospitals, clinics or ambulatory surgery centers which provide the services not available at the admitting hospital.

Transportation

When a Medicaid patient is admitted to a hospital, the hospital is reimbursed in their inpatient rate for all transportation services for the patient.

If the admitting hospital sends a Medicaid inpatient (round-trip) to another hospital for the purposes of obtaining a diagnostic or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services and the reimbursement of the ambulance or other transportation service for the transport of the patient.

The transport will not be authorized by the Medicaid program. The costs of transportation are to be incurred by the hospital.

For example, Hospital A arranges for the round-trip transport to Hospital B of a Medicaid inpatient by an ambulance for a diagnostic, magnetic resonance imaging test. Hospital A should reimburse the transportation provider for the transport of the inpatient.

Section III - Basis of Payment for Services Provided

Diagnosis Related Groups: 20 Most Frequently Billed

Annually, the Bureau of Health Economics determines the 20 most frequently billed Diagnosis Related Groups (DRGs). Below is the new DRG table for Medicaid payments to New York State hospitals.

The new table is effective for discharges beginning January 1, 2007.

When payment for one of these DRGs is indicated, the remittance statement will list rate code 2996 rather than 2946.

The **Service Intensity Weight** table for New York State hospitals can be found at:

www.health.ny.gov/nysdoh/hospital/drg/drgs.htm

Top 20 Diagnosis Related Groups: Effective discharge date January 1, 2007

DRG #	DIAGNOSIS RELATED GROUP NAME
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC
127	HEART FAILURE & SHOCK
143	CHEST PAIN
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORD AGE >17 W/O CC
209	MAJ JOINT & LIMB REATTACHMENT PROCEDURE OF LOW EXT, EXC HIP, EXC FOR COMP
359	UTERINE & ADNEXA PROC FOR CA IN SITU & NONMALIGNANT W/O CC
370	CESAREAN SECTION W CC
371	CESAREAN SECTION W/O CC
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O CDE W/O CC
627	NEONATE, BWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB
628	NEONATE, BWT >2499G, W/O SIGNIF OR PROC, W MINOR PROB
629	NEONATE, BWT >2499G, W/O SIGN OR PROC, W NORM NEWB DIAG
775	BRONCHITIS & ASTHMA AGE <18 W/O CC
814	NONBACTERIAL GASTROENTERITIS & ABDOMINAL PAIN AGE >17 W/O CC
854	PERCUTANEOUS CARDIOVASCULAR PROCEDURE W DRUG-ELUTING STENT W/O AMI
883	LAPAROSCOPIC APPENDECTOMY
886	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE

Questions? Contact the Division of Medical Review and Provider Enrollment, Rate Based Provider Unit at (518) 474-8161.

Other Third-Party Insurance Involved

Any third-party health insurance the patient has must be billed prior to billing the Medicaid Program.

Maximum reimbursable charges will be determined by the New York State Department of Health (NYSDOH) for each voluntary, proprietary, and public hospital which is qualified to participate in the Medicaid Program. These charges are all-inclusive rates.

No extra charges will be allowed unless, under extraordinary circumstances, special items were omitted from the hospital cost statement which was used to determine the reimbursable charge.

Hospitals may only bill for days of service which were determined to be appropriate by the authorized utilization review agent.

If a patient is seen in the hospital's emergency room or outpatient clinic and is subsequently admitted to the hospital on the same day, Medicaid reimbursement will be limited to the hospital's inpatient rate. The hospital may not bill for the emergency room or clinic services provided on the day of admission.

For reimbursement purposes the date of admission, but not the date of discharge, may be counted as a day of care. In no instance will the date of discharge be reimbursable.

Out-of-State Facilities

For inpatient care provided by a hospital outside of New York State, Medicaid will reimburse for charges as billed by the hospital.

Reimbursement, however, will not exceed the Medicaid rate established for that hospital by the agency in which the hospital is located.

Payment to Salaried Physicians

Medicaid reimbursement for inpatient care by a hospital-based physician on salary is authorized if the portion of the physician's salary allocated for patient care is excluded as a cost element in the determination of the hospital's Medicaid rate.

Medicaid reimbursement to the physician for direct patient care is available if the physician is paid by the hospital for his responsibilities in such areas as research, teaching, or administration, but not for direct patient care.

In such cases, the determination of the hospital's rate should not reflect any cost for patient care by that physician.

The physician's contract with the hospital should clearly indicate that his responsibilities do not include direct patient care but are limited to other areas.

If a physician utilizes hospital resources (e.g., office equipment, personnel) to earn income from private practice, the cost of such resources should be excluded in the rate

Medicare Liability for Patients in Alternative Level of Care

Under certain circumstances, Medicare is obliged to pay for a hospitalized Medicare patient's stay when that patient is waiting for a bed to become available in a Medicare-participating skilled nursing facility (SNF).

When the Medicare patient is also Medicaid-eligible, Medicare should pay for part of the patient's care for those days during which the individual is awaiting placement in a qualified SNF.

The only exception to Medicare participation in reimbursement occurs when:

- the patient remains hospitalized while awaiting placement in a level of care other than SNF care; or
- the patient has exhausted all available Medicare days.

In these cases, Medicaid will be liable for the alternate level of care for the Medicare-Medicaid payment, if the patient has Medicaid coverage of covered medical care and services, including nursing facility services.

Hospital bills will be reviewed to determine whether an inpatient was eligible for Medicare at the time of hospitalization and that Medicare was billed for its maximum share. On all claims for patients in alternate level of care, the hospital must submit the appropriate level of care information on the electronic claim.

Medicare Payment for Non-Physician Services

Non-physician services provided to Medicare-eligible patients by entities other than the inpatient hospital must be provided by the hospital as a Part A benefit when the patient has Part A coverage.

The ancillary service provider must bill the hospital directly for any non-physician services provided to the patient.

Sometimes a Medicaid patient is not eligible for Part A or has exhausted Part A benefits but has Part B coverage. Medicaid would be billed in these cases but Medicare must also be billed for any Part B covered ancillary services.

The ancillary service provider must bill the inpatient hospital for his services and accept the hospital's payment as payment in full.

The inpatient hospital must bill Medicare for the Part B services.

If the ancillary services are included in the Medicaid per diem, Part B payments received by the hospital must be reported.

In those rare instances when the Part B service is not included in the Medicaid per diem, the hospital may bill Medicaid for the co-insurance and deductible.

Medicare Liability and Use of Medicare Lifetime Reserve

If a Medicaid/Medicare patient chooses not to use his/her lifetime reserve days, the patient is then completely responsible for payment of these days.

Reserved Bed Policies

Medicaid payments are available to reserve the bed of a patient in a SNF, health related facility (HRF) or intermediate care facility for the mentally retarded (ICF/DD) during hospitalization of that patient.

For bed reservation purposes, "hospitalization" refers to temporary stays in acute care, psychiatric or rehabilitation hospitals as a result of acute episodes in a patient's condition which cannot be treated in the SNF, HRF, ICF/DD in which the patient resides.

Hospital responsibilities under bed reservation policy during hospitalization of a SNF, HRF, or ICF/DD resident are outlined in *Hospital Memoranda 78-96* and *79-47*.

Form DSS-3074, *Status of Bed Reservation*, must be prepared for each SNF, HRF or ICF/DD patient being hospitalized. Instructions for completion of this form may be found in *Health Facilities Memorandum 79-72*.

The bed of a patient in a certified psychiatric or rehabilitation unit of a general hospital may be reserved for therapeutic leave purposes **only**. It may not be reserved in the unit if the patient is temporarily absent overnight while receiving another acute level of care service elsewhere within the same general hospital or in another medical inpatient facility.

A general hospital may claim reimbursement for bed reservation fees only for patients being cared for in psychiatric/rehabilitative units of the hospital during a therapeutic leave, but only when the requirements outlined in *Health Facilities Memorandum 78-96* are met. This document is available at the regional office of the Office of Health Systems Management, and online at:

http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/96adm1.pdf.

Policy questions regarding this matter and concerning hospital payments for SNF and HRF patients should be addressed to the New York State Office of Health Insurance Programs Division of Medical Review and Provider Enrollment.

Policy questions concerning hospitalized ICF/DD patients should be addressed to the appropriate County Service Group Office of the State Office of Persons with Developmental Disabilities.

Unique Situations Requiring Special Billing Procedures

The Medicaid payment system cannot process electronic claims when certain conditions apply. In these situations, the hospital can receive payment by submitting a paper claim form, Medicare and/or other third party benefit statements, and a cover letter to the Medicaid Program for processing. If approved, a separate check will be mailed to the hospital. The two-year billing rules, as described in the [Information for All Providers – General Billing Manual](#), also apply in this circumstance.

Following are situations where an "offline" payment will be processed for care provided to eligible clients:

- ↗ Patient is Medicaid eligible at admission and becomes Medicare eligible during the stay. In this case, Medicare will make a DRG payment based on services rendered from the first day of Medicare entitlement.
 - Medicaid will compare the Medicare-paid DRG to the Medicaid DRG (which is based on the entire stay).
 - If the DRGs differ, and the Medicaid-only payment exceeds the Medicare payment, Medicaid will pay the difference plus any Part A deductibles, coinsurance and LTR days that may be appropriate. (Please note: it may be appropriate to bill a portion of the stay electronically. You will be advised at the time your case is reviewed.)
- ↗ Partial Part A payment is denied because another partial Part A payment was made for the same spell of illness (remittance denial message 01129).
- ↗ Patient is covered by a Medicare managed care plan, and the plan leaves a patient responsibility that is greater than traditional Medicare deductibles or coinsurance amounts.

The documentation noted above should be mailed to:

(Note: Mailing address changed as of 6/20/2023)

New York State Department of Health
Office of Health Insurance Programs
Bureau of Medical Review
1 Commerce Plaza, Room 1206
Albany, New York 12260

Utilization Review, Alternate Care Placement and Discharge Review Program

Hospitals shall comply with the Federal regulations regarding utilization review, including 42 CFR Part 482 and NYSDOH Regulation 405.26.

Hospitals must be diligent in their review of inpatient admissions to ensure compliance with Medicaid billing policies and the medical necessity requirements for inpatient claims. This involves thoroughly evaluating whether the medical factors documented in the medical record

support the appropriateness of the inpatient admission, the duration of the stay and the professional services, including drugs and biologicals. Utilization review teams play a critical role in verifying that these criteria are met before submitting a claim to Medicaid. All supporting documentation must be retained for six years for fee-for-service members and for ten years for managed care members from the date of payment and made available upon request to substantiate the claim during post-payment reviews.

All patients admitted to units having an operating certificate granted by the New York State Division of Alcoholism and Alcohol Abuse for the operation of an acute care alcoholism program or inpatient rehabilitation program shall be subject to the admission, continuation of stay, care plan, staffing, services and discharge requirements of applicable State regulations, including 14 NYCRR Parts 374 and 381.

Hospitals are required to meet the requirements of the Hospital Discharge Review Program which provides a discharge appeal by the Independent Review Agent or (IPRA). The IPRA for Medicaid Hospital patients is the Island Peer Review Organization (IPRO).

Questions concerning utilization review, alternate level of care policies and Hospital Discharge Review Program should be directed to the NYSDOH's contracted entity, IPRO at:

IPRO (Island Peer Review Organization)
Medicaid/State Healthcare Assessment Department
1979 Marcus Avenue
Lake Success, New York 10042-1002

Telephone
(516) 326-7767 ext. 361

Section IV - Definitions

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

Hospital

A hospital is a facility or institution engaged principally in providing services by or under the supervision of a physician, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition.

The term hospital does **not** include:

- ↗ an institution, sanitarium or facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the Office of Mental Health except for those distinct parts of such a facility which provide hospital service; nor
- ↗ a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings.

Hospital Discharge

For purposes of payment under the case-based payment system, an inpatient shall be defined as discharged when the patient's admission to the facility occurred on or after January 1, 1988, and:

- ↗ the patient is released from the facility to a non-acute care setting;
- ↗ the patient dies in the facility;
- ↗ the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services. Such infants shall be classified as transfer patients; or
- ↗ it is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

Hospital Transfers

A transfer patient shall be defined for purposes of transfer payments as a patient who:

- ↗ is not discharged;
- ↗ is not transferred among two or more divisions of merged or consolidated facilities;

- ↗ is not assigned to a Diagnosis Related Group (DRG) specifically identified as a DRG for transferred patients only, and
- ↗ who meets one of the following conditions:
 - is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system;
 - is transferred to an out-of-state acute care facility; or
 - is a neonate who is being transferred to an exempt hospital for neonatal services.

Transfers shall include, but not be limited to, transfers between more than two acute care facilities, and transfers from those hospitals excluded from the DRG case-based payment system because of participation in an approved Medicaid cost control program or demonstration, to a hospital reimbursed pursuant to the DRG case-based payment system.

Inpatient

An inpatient is an individual who has been admitted to a hospital on the recommendation of a physician or dentist and is receiving room, board, and professional services in the hospital where patients generally stay overnight.

Inpatient Hospital Services

Inpatient hospital services are those items and services, provided under the direction of a physician or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Included in such services are:

- ↗ the room,
- ↗ dietary and nursing services,
- ↗ minor medical and surgical supplies and
- ↗ the use of certain equipment and facilities for which the hospital does not customarily make a separate charge.

Institutionalized Individual

An institutionalized individual refers to one who is either:

- ↗ involuntarily confined or detained under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or

- ↗ confined under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Medically Incompetent Individual

A mentally incompetent individual refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Medically Necessary Services

Medically necessary services are those necessary to prevent, diagnose, correct or cure conditions in a person that:

- ↗ cause acute suffering,
- ↗ endanger life,
- ↗ result in illness or infirmity,
- ↗ interfere with his/her capacity for normal activity or threaten some significant handicap and
- ↗ which are furnished an eligible person in accordance with the regulations of the Department.