



**NEW YORK STATE
MEDICAID COVERAGE
AND DIABETES**

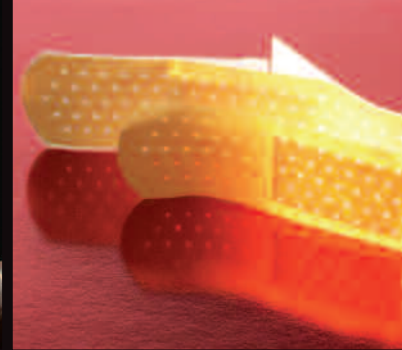
**FACT SHEET
FOR CLINICIANS**



ITEM/SERVICES	MEDICAID BENEFIT	MEDICAID PAYS	BENEFICIARY PAYS*
Physician Visits	Physician visits are covered.	100% of the Medicaid fee.	No co-payment.
Clinic Visits	Clinic visits are covered.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment for each clinic visit.
Blood Glucose Monitors	Home blood glucose monitors, replacement batteries, calibrator solution/chips are covered. Only specialized glucose monitors (e.g., voice synthesizer, automatic times etc.) require prior approval.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment for each item.
Test Strips and Lancets	Glucose monitor test strips, lancets and urine test strips are covered.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment when an order is filled for each item.
Syringes, Alcohol Wipes or Pads, Alcohol, Peroxide, Needles, Betadine, Cotton Swabs	Syringes, alcohol wipes or pads, alcohol, peroxide, needles, Betadine, and cotton swabs are covered.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment when an order is filled for each item.
Insulin and Insulin Pens	All insulin products (prescription or over-the-counter) are covered.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment is charged for each new prescription or order and for each refill. Brand name products incur a higher co-payment than generic or over-the-counter agents.
Prescription and Non-Prescription Drugs	Prescriptions and non-prescription drugs are covered. Most brand name drugs with a generic equivalent will require prior authorization to be covered.	100% of the Medicaid fee after the co-payment is incurred.	A co-payment is charged for each new prescription or order and for each refill. Brand name products incur a higher co-payment rate than generic or over-the-counter agents.
Pneumococcal Vaccine Influenza Vaccine	Pneumococcal and Influenza vaccines are covered immunizations.	100% of the Medicaid fee.	No co-payment.
External Infusion Pumps	Insulin pumps and supplies for subcutaneous infusions are covered with prior approval.	100% of the Medicaid fee.	No co-payment for pump. Co-payment is charged for supplies.
Hemoglobin A1C and other Blood Tests	Glycosylated hemoglobin-HbA1C, lipid profile, triglycerides, urinalysis for protein, microalbumin measurement are covered.	100% of the Medicaid fee after the co-payment is incurred.	A co-payment may be charged for each laboratory test.



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<p>Optometry and Ophthalmology Services</p>	<p>Dilated eye exams for diabetic retinopathy, retinal surgery (ophthalmologists only), and other vision services are covered. Coverage limited to an eye exam every two years, unless more frequent exams are medically necessary and documented by the treating physician. A beneficiary is eligible for eyeglasses once every two years. However, if the beneficiary's prescription changes at least a .50 diopter, Medicaid will cover the replacement of the lenses. If glasses are damaged, Medicaid will cover the repair. If glasses are lost or damaged beyond repair, Medicaid will cover a replacement pair of the same frame and same prescription lenses.</p> <p>Contact lenses require prior approval and are covered only when medically necessary.</p>	<p>100% of the Medicaid fee.</p>	<p>No co-payment.</p>
<p>Foot Exams</p>	<p>Comprehensive foot exams are covered when performed by a primary care physician as part of a physician office visit; by a podiatrist for children under age 21 with written referral of a physician, physician assistant, nurse practitioner, or nurse midwife; or for Medicaid beneficiaries who also have Medicare coverage ("dual-eligibles").</p>	<p>100% of the Medicaid fee based on the provider:</p> <ol style="list-style-type: none"> 1. For Physicians: 100% of the Medicaid fee. 2. For Clinic services: 100% of the Medicaid fee after the co-payment is incurred. 3. For Podiatrists: 100% of the Medicaid fee. <ul style="list-style-type: none"> • Clinics that include podiatric services are part of their facility rate. 	<ol style="list-style-type: none"> 1. No co-payment. 2. Co-payment required. 3. No co-payment, except in a podiatric clinic.
<p>Orthotic and Prosthetic Devices</p>	<p>Medically necessary orthotic braces or devices are covered. Prescribers must issue an order, and the item is then dispensed through a Durable Medical Equipment (DME) supplier enrolled in the Medicaid program. Elastic stockings are limited to four pairs per year. Some items may require prior approval.</p>	<p>100% of the Medicaid fee.</p>	<p>No co-payment.</p>
<p>Therapeutic Shoes</p>	<p>Medically necessary orthopedic footwear and supportive devices for the feet are covered. Prescribers must issue an order, and the item must be dispensed through a Durable Medical Equipment supplier or shoe dealer enrolled in the Medicaid program. Therapeutic shoes are limited to two pairs per year, unless there is a change in the beneficiary's medical condition. Prior approval is required for additional pairs of shoes.</p>	<p>100% of the Medicaid fee.</p>	<p>No co-payment.</p>



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Smoking Cessation Programs	The New York State Medicaid Program will provide reimbursement for smoking cessation products. Nicotine replacement therapy, including patches, inhalers, nasal sprays, gum and Zyban, is covered. Orders will be limited to two courses of therapy per recipient per year, with a course of therapy defined as an original one-month initial supply with up to two refills, for a total of a 90-day supply.	100% of the Medicaid fee after the co-payment is incurred.	Co-payment is charged for each new prescription or order and for each refill. Brand name products incur a higher co-payment than generic or over-the-counter agents.
Wound Care Supplies	Protective covers or fillers for openings on the body caused by surgical procedures, wounds, ulcers, or burns are covered.	100% of the Medicaid fee after the co-payment is incurred.	A co-payment is charged when an order is filled.
Home Dialysis Services, Supplies, and Equipment	Home dialysis services, supplies and equipment are covered.	100% of the Medicaid rate after the co-payment is incurred if applicable.	No co-payment for services and equipment. Co-payment is charged for supplies.
Canes, Walkers, Hospital Beds, Oxygen	Some Durable Medical Equipment (DME) and other medical equipment require prior approval.	100% of the Medicaid fee.	No co-payment for DME. Co-payment is charged for supplies (e.g., a cane).
Home Health Visits	Home health services must be ordered by the treating physician, who determines the level of care needed. These services are provided by a certified home health agency, and are provided in 60-day increments. After each 60-day increment, the physician must reauthorize the services if more care is required.	100% of the Medicaid rate.	No co-payment.
Personal Care Visits	Personal care services must be ordered by the treating physician; the level of care is determined by the social service district in which the patient resides. The social service district conducts both a social and nursing assessment to determine what services are necessary. A plan of care is developed based on the physician's order and the two assessments. There is no limit to the amount of personal care services that can be provided. The physician must reauthorize the need for services every six months.	100% of the Medicaid rate.	No co-payment.
Transportation	Medicaid is required to ensure that there is transportation available to medically necessary services, but is NOT required to directly provide the transportation. Medicaid will pay for most forms of transportation such as bus passes, ambulette services, or taxi service to have access to medically necessary services. The physician typically writes the order for transportation services or contacts the county. It is up to the county to make the arrangements.		
Language Interpreter Services	Title VI of the Civil Rights Act of 1964 requires that "no person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or subjected to discrimination under, any program or activity receiving Federal financial assistance." This law covers physicians and other providers who treat Medicaid patients, and is particularly relevant for patients with limited English proficiency. In order to ensure compliance with Title VI, health care providers must take steps to ensure that patients who are limited in their ability to speak English have meaningful access to the health and social service benefits they offer, and that patients have the language assistance necessary to ensure such access at no cost to the patient. Such services are reimbursable to the county by Medicaid. Medicaid does not play a role in the type of interpreters hired, performance requirements, etc. The physician or the recipient must contact the local district to arrange such services which can only be used to discuss medical conditions and not for general activities of daily living.		

*EXCEPTIONS TO CO-PAYMENT RULES:

- Drugs to treat mental illness
- Birth control drugs
- Any drug in an emergency
- Tuberculosis drugs
- Children under 21 years of age
- Pregnant women
- Medicaid recipients enrolled in a Home and Community Based Services Waiver (HCBS) or Comprehensive Medicaid Case Management (CMCM) Program
- People living in community residences certified by the New York State Offices of Mental Health or Mental Retardation and Developmental Disabilities
- Certain institutionalized recipients
- Private practicing physicians' services (including lab and/or x-ray services), home health services, personal care services, or long-term home health care services
- Medicaid recipients living in an adult care facility who receive pharmacy services

- NOTE**
1. Health care providers cannot legally force a Medicaid beneficiary to pay the co-payments or deny a service or benefit if the beneficiary is unable to pay. However, the co-payment amount is a debt that is collectible from the recipient.
 2. There is a co-payment out-of-pocket maximum of \$200 per 12-month period (April 1 through March 31).

EXCEPTIONS TO ANNUAL LIMITS ON SERVICES AND VISITS

Medicaid will pay for a specified number of certain health services per benefit year unless additional services are approved. Utilization limits have been established for pharmacy services, physician and clinic visits, and laboratory procedures. However, some patients may require more services, particularly those with chronic medical conditions like diabetes. A physician may request higher limits or an exemption from limits by submitting a "Threshold Override Application." For questions about service utilization limits, please call Computer Sciences Corporation (CSC) at 800-421-3893 or 518-426-5843.

MEDICAID-MEDICARE RELATIONSHIP: DUAL ELIGIBLES

The Medicare program provides insurance coverage for persons 65 years and older, and for certain individuals with disabilities under the age of 65. Medicare has several parts: Part A covers hospital services and enrollment is automatic for all eligible people. Part B covers physician and other services, and is voluntary; beneficiaries must pay a monthly premium. In addition to the monthly premiums, the Medicare program requires significant cost sharing. Beneficiaries must meet a yearly deductible for Part B coverage, and Part A requires an inpatient hospital deductible for each admission. In addition, there are co-insurances required for many services. Effective January 1, 2006, Medicare will also provide prescription drug coverage and will be the primary payer of this benefit under Part D. Like Part B, there is a monthly premium, yearly deductible, and significant cost sharing. Medicare beneficiaries who have low incomes and limited resources may receive help paying for their out-of-pocket medical and prescription drug expenses from their State Medicaid program. These beneficiaries are often referred to as "dual eligibles." There are different levels of coverage or assistance available, depending on an individual's income.

For persons who are eligible for Medicaid coverage, the Medicaid payment is payment in full. The Medicaid program also supplements Medicare coverage and supplies that are available under New York State's Medicaid program. Services that are covered by both programs will be paid first by Medicare and then by Medicaid, with no out-of-pocket expense to the recipient except the Medicaid co-payment where applicable. Medicaid also covers additional services (e.g., nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs through 2005, eyeglasses, and hearing aids).

FOR MORE INFORMATION ON NEW YORK STATE MEDICAID

Medicaid HELP LINE: 1-800-541-2831

New York State Department of Health: <http://www.health.state.ny.us>

List of Medicaid Reimbursable Drugs: <http://www.emedny.org/info/formfile.html>

PLEASE NOTE: MEDICAID COVERAGE POLICY IS SUBJECT TO CHANGE.





STATE OF NEW YORK
GEORGE E. PATAKI, GOVERNOR

DEPARALTH
ANTONA C.

1-800-541-2831

www.health.state.ny.us