



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.  
*Commissioner*

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*Executive Deputy Commissioner*

## **MEDICAID PREFERRED PHYSICIANS AND CHILDREN PROGRAM**

Beginning October 1, 1990, the New York State Department of Health invites interested physicians meeting certain eligibility and practice requirements to apply to participate in the Medicaid Preferred Physicians and Children Program, hereinafter referred to as PPAC.

### **REIMBURSEMENT**

Physicians participating in PPAC receive increased Medicaid fees for visits provided to Medicaid recipients under 21 years of age. The fee structure for all visits incorporates a regional adjustment for upstate and downstate. The upstate reimbursement for office visits is \$33.63; the figure for downstate is \$39.64. The fees for visits in settings other than office are an enhanced, but fixed fee: \$30 upstate and \$36 downstate.

The counties considered downstate for this program are Bronx, Kings, Queens, New York, Richmond, Nassau, Putnam, Rockland, Suffolk, and Westchester.

### **BILLING**

When billing for care to Medicaid recipients under 21 years of age, for well child care services furnished in an office setting use the CPT-4 Preventive Medicine Services codes 99381-99385 and 99391-99395. For Newborn care services use 99431, 99433 or 99435.

For all other services provided in a practitioner's office or other ambulatory setting, use the Evaluation and Management procedure codes 99201-99205, and 99211-99215. Report the place of service code that represents the location where the services was rendered in claim field 24B, Place of Service. The maximum reimbursable amount for these codes is dependent on the Place of Service reported. The PPAC Section of the Physician Manual defines these codes.

The ancillary services and procedures performed during any visit must be claimed through the use of customary Medicaid procedure codes; these claims will be reimbursed at customary Medicaid fee levels.

## **ELIGIBILITY AND PRACTICE REQUIREMENTS**

The PPAC eligibility and practice requirements for the primary care physician and non-primary care specialist physician appear on pages 3 and 4 of this letter.

## **APPLICATION**

Physicians may apply to participate in PPAC by completing the State Department of Health form: Application for Enrollment as a Medical Specialist, AND Addendum. These two forms **must** be completed by every physician applying to participate in PPAC, the physician already enrolled as a Medicaid provider, the physician applying to enroll as a Medicaid provider and a PPAC participant, and the physician whose enrollment in Medicaid has lapsed and he/she wishes to enroll in Medicaid and participate in PPAC. If the forms necessary to enroll in Medicaid and/or apply to participate in PPAC are not included with this letter, they may be obtained by written request to Computer Sciences Corporation, P.O. Box 4610, Rensselaer, NY 12144 or downloaded from the Internet at [www.emedny.org](http://www.emedny.org).

## **NOTIFICATION**

A letter of decision regarding the physician's application will be sent by this Department to the applicant's correspondence address as listed on the MMIS Provider File. If application for Medicaid enrollment and PPAC participation are made at the same time, the letter of decision regarding the Medicaid enrollment will be sent first, followed at a later date by the letter of decision regarding PPAC participation.

## **QUESTIONS**

Please allow 90 days before you call to request your application status. To inquire about matters of specialty, hospital admitting privilege, required documentation, and the status of your submittal to the New York State Department of Health; please call 1-800-343-9000.

## PHYSICIAN ELIGIBILITY AND PRACTICE REQUIREMENTS

I. The qualified primary care physician will:

- **Have an active hospital admitting privilege at an accredited hospital;**

This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one due to such reason as the unavailability of admitting privilege at area hospitals, or specialty not accepted for admitting privilege at area hospitals, or nearest hospital too distant from office to be practical.

Such physician will submit at time of application (a) a description of the circumstance that merits consideration of waiver of this requirement, and (b) **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a *curriculum vitae*, proof of medical malpractice insurance, and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- **Be board certified (or board admissible for no more than five years from completion of a postgraduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics;**
- **Provide 24-hour coverage for consultation;**

This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients. This requirement *cannot* be met by a recording referring patients to emergency rooms.

- **Provide medical care coordination;**

Medical care coordination will include at a minimum the scheduling of elective hospital admissions, assistance with emergency admissions, management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, and scheduling for necessary ancillary services.

- **Provide periodic health care assessment examination (well care) in accordance with the standards of the Medicaid Child/Teen Health Program;**
- **Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;**

- **Sign an agreement with the Medicaid Program. Such an agreement to be subject to cancellation with a 30-day notice by either party.**

II. The qualified non-primary care specialist physician will:

- **Have an active hospital admitting privilege at an accredited hospital;**

This requirement may be waived for the physician who qualifies for hospital admitting privilege but does not have one due to such reasons, as the practice of his/her specialty does not support need for admitting privilege.

Such physicians will submit at the time of application (a) a description of the circumstance that merits consideration of the waiver of this requirement; and, for the non-primary care specialist who provides specialist care to inpatients but has cause to request waiver of the requirement for active hospital admitting privilege, also (b) **EITHER** a copy of a letter of active hospital appointment other than admitting **OR** evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized; and (c) a *curriculum vitae*; proof of medical malpractice insurance; and two letters of reference, each from a physician who can attest to the applicant's qualifications as a practicing physician.

- **Be board certified (or board admissible for no more than five years from completion of a postgraduate training program) in a specialty recognized by the State Health Department;**
- **Provide consultation summary or appropriate periodic progress notes to the primary care physician on a timely basis following a referral or routinely scheduled consultant visit;**
- **Notify the primary care physician when scheduling hospital admission;**
- **Be a provider in good standing if enrolled in the Medicaid Program at time of application to PPAC;**
- **Sign an agreement with the Medicaid Program, such agreement to be subject to cancellation with a 30-day notice by either party.**

**ATTENTION**

**MEDICAID PREFERRED PHYSICIANS AND CHILDREN PROGRAM (PPAC)**

**Applicants to PPAC must complete this ADDENDUM to *Application for Enrollment as a Medical or Dental Specialist***

- INSTRUCTIONS:**
- (1) Type or print the information in the space provided.
  - (2) Attach required documentation.
  - (3) Sign and date the Assurances.
  - (4) Submit completed Application, Addendum and required documentation to:

**Computer Sciences Corporation  
P.O. Box 4610  
Rensselaer, New York 12144**

**SECTION A – IDENTIFYING INFORMATION**

1. Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

2. License No.: \_\_\_\_\_ State: \_\_\_\_\_

3. Please complete **IF YOU ARE** an enrolled Medicaid Provider:

MMIS #: \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

**SECTION B – PRACTICE INFORMATION**

4. If you employ/use the services of one or more nurse practitioners and/or physician assistants, please give name(s) and license(s) below:

<u><b>NAME</b></u>	<u><b>LICENSE NO.</b></u>	<u><b>STATE</b></u>
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Attach additional pages as necessary.

**SECTION C – ACTIVE HOSPITAL ADMITTING PRIVILEGE (Check ONE):**

5. \_\_\_\_\_ I have an active admitting privilege at an accredited hospital. A copy of my hospital appointment letter is attached.

\_\_\_\_\_ I do not have an active hospital privilege as above for circumstances that I believe merit consideration. I have completed Section E – EXCEPTION.

**SECTION D – ASSURANCES**

6. I recognize that I continue to be bound by the rights, obligations, duties or interests accrued, incurred or conferred as a result of my enrollment in the New York State Medicaid Program.
7. As a preferred primary care physician, I assure the provision of comprehensive medical care services to Medicaid patients below the age of twenty-one years, in accordance with generally accepted standards of medical practice and, for well visits, in accordance with the requirements of the Child/Teen Health Program.
8. As a preferred primary care physician, I agree to provide medical care coordination as a part of my care, such medical care coordination to include at a minimum the scheduling of elective hospital admissions, where possible, assistance with emergency admissions, management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, scheduling for necessary ancillary services, telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care, and the maintenance of a complete medical record to include but not be limited to notation of referrals and hospitalizations, and copies of test results and reports.
9. I assure that patients with Medicaid will be free to choose their primary care physician and will be free to choose, from among qualified providers, the specialist to whom they will be referred.
10. As a participating specialist, I assure that I will provide medical care coordination as necessary to these patients. Such medical care coordination should include at a minimum the scheduling of elective hospital admission, management of participation in hospital care and discharge planning, periodic follow-up reports to the referring primary care provider regarding the plan for and outcomes of specialist services, scheduling for necessary ancillary services, and telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care.
11. As a primary care physician I assure that I will maintain twenty-four hour telephone coverage which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement cannot be met by a recording referring patients to the emergency room.

12. I assure that I will request as necessary from the NYS Department of Health, and display conspicuously on my premises, designated informational materials that serve to inform the public regarding Medicaid eligibility and services for persons under twenty-one years of age and for pregnant women.
13. I assure that I will notify the NYS Department of Health within thirty (30) days of circumstances resulting in *ineligibility* to continue this agreement and/or my *inability* to perform the activities and services required under this agreement.
14. I recognize that the State may determine new visit types and rates during the term of this agreement and that the new visit types and rates may supersede those available at the time of this agreement.
15. I assure that I will abide by all reasonable policies, procedures, and instructions provided by the State to implement and execute the Preferred Physicians and Children Program, and will bill Medicaid in accordance with the reimbursement methodology established by the State.
16. I recognize that the New York State Department of Health may cancel my participation in the Preferred Physicians And Children Program at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the Preferred Physicians And Children Program will include but not be limited to my failure to comply with these assurances, including but not limited to failure to accurately bill Medicaid under the reimbursement methodology established.
17. I recognize that I may request cancellation of my participation in the Preferred Physicians And Children Program when there are extenuating circumstances, giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will include a description of the basis for the request. I agree to continue to provide and/or arrange services for patients up to the date of termination. I assure that I will assist patients to maintain continuity of care, provide them with information to assist them to transfer their care; and make timely transfer of the records upon request.
18. I accept that upon my designation by the New York State Department of Health to participate in the Preferred Physician and Children Program, these Assurances will be effective and may continue in effect thereafter with the consent of both parties and so long as Federal financial participation is available. I accept that services rendered prior to my enrollment will not be eligible for reimbursement through the Preferred Physician and Children Program.

19. PRINT NAME \_\_\_\_\_

20. SIGNATURE \_\_\_\_\_

21. DATE \_\_\_\_\_

**SECTION E – EXCEPTION REQUEST INFORMATION**

1. Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

2. (a) License Number: \_\_\_\_\_ (b) State: \_\_\_\_\_

3. IF YOU ARE an enrolled Medicaid provider, please provide your  
MMIS #: \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

**CHECK EITHER 4(A) OR (B) AND (C)**

4. (A) \_\_\_\_\_ Attached is a brief summary of the circumstances that support my request for waiver of the requirement to have an active hospital admitting privilege.

(B) \_\_\_\_\_ I have attached a copy of a letter of active hospital appointment other than admitting privilege.

\_\_\_\_\_ I have attached documentation of an agreement between myself and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to my patients who are hospitalized.

AND

(C) \_\_\_\_\_ I have attached my *curriculum vitae* and proof of current medical malpractice insurance coverage and two letters of reference, each from a physician who can attest to my qualifications as a practicing physician.

## New York State Department of Health Application for Enrollment as a Specialist

1. Type or print the information requested in the space provided.
2. Submit a copy of one of the following appropriate documents:
  - a. certification by an appropriate specialty board; or
  - b. notice of admissibility to final examination from appropriate specialty board; or
  - c. evidence of satisfactory completion of residency or fellowship training.

### Section A - Applicant Information

1. Name \_\_\_\_\_  
Last First MI
2. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. License Number \_\_\_\_\_ State \_\_\_\_\_  
National Provider Identifier (NPI) \_\_\_\_\_ Provider # \_\_\_\_\_
4. Social Security # \_\_\_\_\_
5. Specialty(ies) Requested \_\_\_\_\_  
Code Numbers (see page 2) \_\_\_\_\_

### Section B - Education and Training Institutions

- Medical/Dental – Name & City, State \_\_\_\_\_
- Degree/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY
- Internship – Name & City, State \_\_\_\_\_
- Degree/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY
- Residency – Name & City, State \_\_\_\_\_
- Degree/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY
- Fellowship – Name & City, State \_\_\_\_\_
- Degree/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY

### Section C - Hospital Appointment Information (for last five years only)

- Name & City, State \_\_\_\_\_ Hours/Week \_\_\_\_\_
- Title/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY
- Name & City, State \_\_\_\_\_ Hours/Week \_\_\_\_\_
- Title/Specialty \_\_\_\_\_ From      /      /      to      /      /       
MM / YY MM / YY

### Section D - U.S. Specialty Board Certification(s)

- Name of Board \_\_\_\_\_ Certification Date      /      /       
MM / DD / YY
- Name of Board \_\_\_\_\_ Certification Date      /      /       
MM / DD / YY

### Section E - Orthodontists Only

- If not in exclusive practice, what % of practice is devoted to orthodontics? \_\_\_\_\_ %
- General Practice From      /      /      to      /      /       
MM / DD / YY MM / DD / YY
- Orthodontics From      /      /      to      /      /       
MM / DD / YY MM / DD / YY

Original Signature \_\_\_\_\_

Date \_\_\_\_\_

## PROVIDER SPECIALTY CODES PHYSICIAN SPECIALTY CODES

<u>CODE</u>	<u>SPECIALTY</u>	<u>CODE</u>	<u>SPECIALTY</u>
010	<b>ALLERGY AND IMMUNOLOGY</b>		<b>PEDIATRICS</b>
		150	Pediatrics
020	<b>ANESTHESIOLOGY</b>	151	Pediatric Cardiology
		152	Pediatric Hematology-Oncology
102	<b>ASTHMA EDUCATOR</b>	<b>154</b>	Pediatric nephrology
		155	Neonatal-Perinatal Medicine
	<b>DERMATOLOGY</b>	156	Pediatric Endocrinology
040	Dermatology	157	Pediatric Pulmonology
041	Dermatopathology	161	Pediatric Critical Care
		163	Pediatric Gastroentology
103	<b>DIABETES EDUCATOR</b>		
		160	<b>PHYSICAL MEDICINE &amp; REHABILITATION</b>
250	<b>EMERGENCY MEDICINE</b>		
		162	<b>OSTEOPATHIC MANIPULATIVE MEDICINE</b>
050	<b>FAMILY PRACTICE</b>		
			<b>PREVENTIVE MEDICINE</b>
	<b>INTERNAL MEDICINE</b>		General Preventive Medicine
060	Internal Medicine	182	Occupational Health
062	Cardiovascular Disease	183	Public Health
063	Endocrinology & Metabolism	184	Aerospace Medicine
064	Gastroenterology	185	
065	Hematology		
066	Infectious Disease		
067	Nephrology		
068	Pulmonary Disease	191	<b>PSYCHIATRY AND NEUROLOGY</b>
069	Rheumatology	192	Child Psychiatry
241	Medical Oncology	193	Psychiatry
		194	Child Neurology y
		195	Neurology
080	<b>NUCLEAR MEDICINE</b>		Psychiatry and Neurology
	<b>OBSTETRICS AND GYNCOLOGY</b>		
089	Obstetrics and Gynecology		
092	Maternal & Fetal Medicine	200	<b>RADIOLOGY</b>
093	Reproductive Endocrinology	201	Radiology
242	Gynecologic Oncology	202	Diagnostic Radiology
			Diagnostic Radiology with Special Competence in Nuclear Radiology
100	<b>OPHTHALMOLOGY</b>	205	Therapeutic Radiology
120	<b>OTOLARYNGOLOGY</b>	187	<b>MEDICAL GENETICS</b>
	<b>PATHOLOGY</b>		<b>SURGERY</b>
131	Blood Banking	030	Colon and Rectal Surgery
135	Clinical Pathology	070	Neurological Surgery
136	Forensic Pathology	110	Orthopedic Surgery
137	Hematology	153	Pediatric Surgery
138	Chemical Pathology	170	Plastic Surgery
139	Medical Microbiology	210	General Surgery
141	Neuropathology	220	Thoracic Surgery
142	Anatomic Pathology		
143	Dermatopathology	230	<b>UROLOGY</b>
146	Anatomic & Clinical Pathology		
148	Radioisotopic Pathology		

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## DENTAL SPECIALTY CODES

<u>CODE</u>	<u>SPECIALTY</u>	<u>CODE</u>	<u>SPECIALTY</u>
801	Orthodontics	806	Periodontics
802	Endodontics	807	Public Health
803	Oral Pathology	808	Oral Surgery
804	Pedodontics	809	Dental Anesthesiology
805	Prosthodontics	810	Parenteral Conscious Sedation