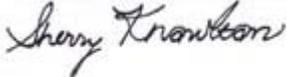


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Basic Health Care for Adult General Assistance Recipients	BY  Sherry Knowlton Acting Deputy Secretary for Medical Assistance Programs
NUMBER:	99-92-07	
ISSUE DATE:	December 23, 1992	
EFFECTIVE DATE:	January 1, 1993	

PURPOSE:

The purpose of this bulletin is to notify providers of changes in medical assistance benefits for some adult general assistance (G.A.) recipients.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance Program.

BACKGROUND:

The Department amended 55 Pa. Code Chapter 1101 to preserve a basic health care package for G.A. recipients, age 21 to 65, that will provide a primary care package of medical services. The package includes most primary and preventative health care services and inpatient hospital care, places additional limitations on some services, and increases the amounts of recipient copayments.

Categorically needy and medically needy G.A. recipients under 21 years of age are not affected by these amendments and remain eligible for all medically necessary medical services. In addition, categorically needy and medically needy G.A. recipients who are pregnant women, migrants, refugees who have been in the United States eight months or less, persons who have applied for Social Security or Supplemental Security Income (SSI) benefits are not affected by these amendments and remain eligible for all medically necessary services covered under the categorically needy and medically needy only categories of medical assistance.

Aid to families with Dependent Children (AFDC) and Supplemental Security Income (SSI) recipients are not affected by these amendments.

DISCUSSION:

Effective January 1, 1993, the Department will implement modifications to medical assistance benefits for G.A. recipients, age 21 to 65, whose medical assistance benefits are funded solely by state funds.

WHAT SERVICES REMAIN THE SAME?

All G.A. recipients who receive one of the categories of assistance affected by the change, regardless of whether they are categorically needy (blue Medical Services Eligibility card) or medically needy (green Medical Services Eligibility card) will be eligible for the services provided by the following enrolled provides with no change to the current coverage:

- Ambulatory Surgical Center
- Outpatient Drug and Alcohol Clinic
- Inpatient Private and Public Psychiatric Hospital
- Psychiatric Partial Hospitalization
- Nursing Facility
- Hospice

- Laboratory and X-Ray
- Inpatient Hospital
- Short Procedure Unit
- Nurse Midwife
- Renal Dialysis Center
- Birth Center
- Intermediate Care Facility for the Mentally Retarded
- Funeral Director

An additional service included with no change in current coverage for categorically needy (blue card) G.A. recipients only is as follows:

- Medical Supplies and Equipment

NOTE: ALL CURRENT REGULATIONS AND LIMITATIONS ON MEDICAL ASSISTANCE PROGRAM SERVICES WILL CONTINUE TO APPLY TO G.A. RECIPIENTS.

WHAT SERVICES HAVE ADDITIONAL/NEW LIMITS?

The services provided by the following enrolled providers have limits in addition to the current limits on Medical Assistance Program services for both categorically needy (blue card) and medically needy (green card) G.A. recipients affected by the change:

- Practitioner's* Office and Clinic** Visits - Limited to a combined maximum of 18 visits per year***.
- Home Health Agency Visits - Limited to a maximum of 30 visits per year***.
- Freestanding Drug and Alcohol Rehabilitation Hospitals and Drug and Alcohol Detoxification/Rehabilitation Units of General Hospitals - Up to 30 days per year***.
- Freestanding Medical Rehabilitation Hospitals and Medical Rehabilitation Units of General Hospitals - Up to 30 days per year***.
- Emergency Room - Emergency services only.
- Ambulance - Emergency transportation only.

* Practitioners include: physicians, podiatrists, chiropractors, optometrists, and certified registered nurse practitioners.

** Clinics include: independent medical clinics, rural health clinics, general and rehabilitation hospital clinics, family planning clinics, and federally qualified health centers.

*** For purposes of tallying annual limits, a year is defined as the state fiscal year, July 1 through June 30.

Services included with additional limits that are compensable for categorically needy (blue card) G.A. recipients are as follows:

- Dental - Limited to surgical procedures and emergency services. Emergency services include palliative treatment, and diagnostics, restorations and/or extractions related to the need for palliative treatment.
- Pharmaceuticals - Limited to three prescriptions/refills per month from the following classes of drugs:
 - A. Anti-infectives (including all oral, parenteral, topical, ophthalmic, otic, vaginal, or rectal products containing antibiotics, antifungals, sulfonamides, antimalarial preparations, antituberculosis agents, ambedicides, antiviral agents, leprostatics, anthelmintics, and urinary anti-infectives either alone or in combination with other drugs)
 - B. Cardiovascular preparations (including all single entity or combination products containing diuretics, cardiac glycosides, antianginal agents, antiarrhythmic agents, calcium channel blocking agents, peripheral vasodilators, beta-adrenergic blocking agents, alpha/beta-adrenergic blocking agents, antihypertensives, antihyperlipidemics, antiplatelet agents, coagulants, and anticoagulants)

- C. Antidiabetic agents
- D. Anticonvulsants
- E. Psychotherapeutic drugs (including all forms of antianxiety agents, antidepressants, and antipsychotic agents)
- F. Antineoplastic agents
- G. Antiglaucoma drugs (including oral and ophthalmic products)
- H. Antiparkinson agents
- I. Family planning drugs
- J. AIDS specific drugs
- K. Asthma specific drugs (all oral and inhalation bronchodilators and antiasthmatic combinations)
- L. Ulcer drugs (limited to oral and parenteral forms of Histamine H₂ Antagonists, Misoprostol, Omeprazole, and Sulcralfate)
- M. Pain Medications (including all oral, parenteral, rectal, topical and transdermal products of analgesics, anti-inflammatory agents, and antirheumatic agents)
- N. Insulin (NOTE: Syringes and needles are compensable under medical supplies and equipment)

Compensability of drugs for G.A. recipients affected by the additional limits can be verified through the Drug Verification System (DVS), 1-800-292-2820.

NOTE: G.A. recipients enrolled in an HMO or HealthPASS are entitled to the range of services described above. HMO's or HealthPASS may choose to provide more services to G.A. recipients than those described in the G.A. basic health care package. Providers affiliated with an HMO or HealthPASS who provide services to medical assistance recipients should contact the plan directly with benefit and reimbursement questions.

COPAYMENT

Copayment amounts will also change for G.A. recipients who receive one of the categories of assistance affected by the change. The amounts of the co-payment these recipients will be expected to pay the provider are as follows:

- Prescriptions - \$2.00 per prescription and refill for all drugs covered under this package.
- Inpatient Hospital - \$6.00 per day of inpatient care, not to exceed \$42.00 per admission.
- Total component or technical component of diagnostic radiology, nuclear medicine, radiation therapy, medical diagnostic - \$2.00 per service.
- Outpatient psychotherapy - \$1.00 per unit of service.
- For all other outpatient services, the copayment amount is as follows:

If the medical assistance fee is \$2.00 - \$10.00, the co-payment is \$1.00.

If the medical assistance fee is \$10.01 - \$25.00, the co-payment is \$2.00.

If the medical assistance fee is \$25.01 - \$50.00, the co-payment is \$4.00.

If the medical assistance fee is \$50.01 or more, the co-payment is \$6.00.

The cap on the copayment is \$180 per six months.

Services excluded from the copayment requirement, listed in §1101.63(b)(2), continue to apply to G.A. recipients affected by the new co-payment requirement with the exception of §1101.63(b)(2)(xv), specific drugs identified by the Department. These drugs will require a \$2.00 copayment per prescription and per refill.

WHICH G.A. RECIPIENTS ARE AFFECTED BY THESE CHANGES?

G.A. recipients, age 21 to 65, whose medical assistance benefits are funded solely by state funds, with no federal financial participation, will be included in the modified basic health care coverage.

All recipients 21 years old or older receiving one of the following categories of assistance and program status codes will be affected by the modified basic health care coverage:

Category	Program Status Code(s)
D	00
K	00
PD	00, 21, 22
PK	00, 21, 22, 23
TD	00
TK	00

The provider can identify the affected G.A. recipient by looking at the category and program status code printed on the recipient's Medical Services Eligibility Card. The category field is identified by the heading "CAT"; the program status code is identified by the heading "PGM STATUS". Both fields are located in the upper right corner of the card.

<input type="checkbox"/> ACTED SERVICES WHEN INDICATED: <input type="checkbox"/> PHARMACY <input type="checkbox"/> PHYSICIANS <input type="checkbox"/> OTHER <input type="checkbox"/> CASE MGT THE SERVICES CHECKED ABOVE CAN BE FURNISHED ONLY BY THE PROVIDER BELOW.		VALID THROUGH 07/24/92		
		CASE NUMBER CD. RECORD NO. CAT CTR DIC 22 0000481 D * 6		
INSTRUCTIONS TO PROVIDER SERVICE WILL BE PROVIDED IN ACCORDANCE WITH THE DEPARTMENT OF PUBLIC WELFARE REGULATIONS AND HANDBOOK. THE PERSON SHOWN IN THE ADDRESS BLOCK MAY NOT ALWAYS BE ELIGIBLE. THIS PERSON IS ELIGIBLE ONLY IF SHOWN WITH A LINE NUMBER.	LINE NO. 01 DOE 02 DOE **	NAME MARY JOHN *****	SOC-SEC-NO. S BIRTHDATE RESOURCES A 194-39-8677 F 05/19/48 B 161-31-7404 M 08/01/73 * *****	PGM STATUS 00 ** OTHER RESOURCES WHEN ONE OF THE RESOURCE CODES LISTED BELOW IS SHOWN PAYMENT MUST BE SOUGHT FROM THE RESOURCE PRIOR TO INDICATING MEDICAL ASSISTANCE. 1 MEDICARE PART-B 2 BLUE CROSS 3 BLUE SHIELD 4 CHAMPUS 5 MEDICARE PART-A 7 OTHER
	SERIAL NO. 01000041		CASE NAME & ADDRESS MARY A DOE 114 SOUTH FRONT ST HARRISBURG PA 17104	
DAUPHIN CAO 2432 N SEVENTH ST HARRISBURG PA 17110		 CLIENT'S SIGNATURE		

*EXAMPLE OF CATEGORY ON THE MEDICAL SERVICES ELIGIBILITY CARD

**EXAMPLE OF PROGRAM STATUS CODE ON THE MEDICAL SERVICES ELIGIBILITY CARD

WHICH G.A. RECIPIENTS ARE NOT AFFECTED BY THESE CHANGES?

- All G.A. recipients under age 21 regardless of whether they are categorically needy (blue card) or medically needy (green card) will continue to receive all services currently covered under the Medical Assistance Program. They are not affected by the change. The provider can determine if the G.A. recipient is under age 21 by reviewing the "BIRTHDATE" printed on the Medical Services Eligibility Card.
- G.A. recipients whose medical assistance benefits are eligible for federal financial participation will continue to receive the same services currently covered under the Medical Assistance Program.
- If a G.A. recipient is in one of the general assistance categories of assistance and program status codes listed below, there are no changes to current medical assistance benefits:

Category	Program Status Code(s)
D	02, 04, 05, 15, 50, 51, 52
K	04, 15, 50, 51, 52
PD	02, 04, 50, 51, 52
PK	04, 50, 51, 52
TD	02, 04, 11, 50, 51, 52
TK	04, 11, 50, 51, 52

EXAMPLE: In the sample Medical Services Eligibility Card, the category is "D" and the program status code is "00". Line number 01, Mary A. Doe, is over age 21. Therefore, Mary A. Doe's medical assistance benefits are affected by the change because of her category, program status code, and age (21 to 65). Line Number 02, John B. Doe, is under age 21. His medical assistance benefits are not affected by the change. Although the category is "D" and the program status code is "00", he continues to be eligible for all services currently covered under the Medical Assistance Program because of his age, which is under 21 years.

INFORMING PROVIDERS OF RECIPIENT USAGE OF PRACTITIONER/CLINIC VISITS AND PRESCRIPTION DRUGS

The provider will be able to determine if a recipient has reached his/her limit for practitioner's office/clinic visits or prescription drugs by means of a paper voucher system. The paper voucher system will remain in effect until on-line electronic verification systems are in operation.

The Department will distribute the appropriate number of paper vouchers to the recipient. The recipient must present both the voucher and his/her current Medical Assistance ID card to the medical provider before obtaining services. The medical provider must check the identifying information on the voucher and the ID card to make certain they are both for the same person and are valid on the date of service. The voucher must then be signed and dated by the recipient or his/her authorized representative before service is provided.

If a recipient loses his/her vouchers, instruct him/her to contact the County Assistance Office to obtain replacement vouchers.

If a recipient indicates that he/she has used all of his/her vouchers, determine if the recipient is eligible for an exception to the limit, based on the exception criteria outlined in Medical Assistance Bulletin 1101-92-01. If the recipient is not eligible for an exception, inform the recipient that the service will not be compensable under the Medical Assistance Program, and he/she is liable for payment.

NOTE: For detailed information on the voucher system, please refer to Medical Assistance Bulletin 01-92-17, 04-92-07, 07-92-02, 10-92-07, 11-92-18, 15-92-05, 19-92-13, 26-92-03, 30-92-03, 49-92-06.

NEXT STEPS:

1. Before providing a service to a G.A. recipient, be sure to:

- a. Ask to see the recipient's Medical Services Eligibility Card. Check the "VALID THROUGH" date.
- b. If valid on the date of service, determine the age of the recipient needing service and if the service is compensable under the Medical Assistance Program. If the recipient is under 21 years of age and the service is compensable, provide the service.
- c. If the recipient is age 21 to 65, determine if the recipient is categorically needy (blue card) or medically needy (green card) and if the service is compensable.
- d. If compensable, identify the recipient's category of assistance and program status code. If the recipient is not affected by the additional limits, provide the service.
- e. If the recipient is subject to the additional limits and the service is a compensable practitioner's office/clinic visit or a compensable prescription drug and the recipient is affected by the increased limits:
 - Ask the recipient for his/her voucher for the service.
 - If the recipient reports that he/she does not have a voucher because he/she has reached the limit, determine if the recipient is eligible for an exception to that limit. (Refer to Medical Assistance Bulletin 1101-92-01 for information on the exception process).
 - If the recipient has reached the limit and is not eligible for an exception, inform the recipient that the service will not be compensable under the Medical Assistance Program.
- f. If the service is not compensable, for any reason, inform the recipient before the service is provided that it is not covered under the Medical Assistance Program and the recipient will be responsible for payment.

2. Refer to the attached matrix to determine what services are compensable for each category of assistance and program status code combination and when additional limits apply to G.A. recipients.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.