

**OPWDD REVENUE SUPPORT FIELD OPERATIONS
MEDICAID COVERAGE DESCRIPTION CHART**

ePACES/POS MESSAGE ELIGIBILITY INFORMATION	IREF CODE WMS		MEDICAID COVERAGE CODE DESCRIPTION	COVERAGE	PROOF OF RESOURCES (D = Document or A = Attest)	ELIGIBLE FOR HCBS WAIVER and ICF/DD SERVICES?	ELIGIBLE FOR MSC SERVICES?
Active Coverage	A	01	FULL COVERAGE	Coverage for all Medicaid covered services/supplies.	D (60 Months)	Y	Y
Exclusions (Service Type 48 & 54)	C	02	OUTPATIENT COVERAGE	Coverage for outpatient care only. No coverage for hospital, ICF, or nursing home room & care. Allows payment for ambulatory care, including prosthetics, up to 29 consecutive days of short term rehab in a NH in a 12-month period, waiver services. (Spendedown)	D (60 Months)	Y* *No coverage for ICF/DD	Y
	X	03	CATASTROPHIC	Historical only; no longer valid coverage.	Discontinued	N	N
Non Covered	N	04	NO COVERAGE - INELIGIBLE	Not covered for Medicaid services.	NA	N	N
Non Covered	K	05	SANCTIONED	Individual is sanctioned from the case.	NA	N	N
Spendedown	V	06	PROVISIONAL - EXCESS INCOME	Not covered for Medicaid services until a spendedown of excess income/resources is met.		N	N
Limitations (Service Type 86)	E	07	EMERGENCY SERVICES ONLY	Coverage for medical services/supplies related to the medical emergency only.	A (Current)	N	N
Limitations (Presumptive Eligibility Long-Term/Hospice)	H	08	PRESUMPTIVE ELIGIBILITY HOME CARE	Coverage for all Medicaid covered services except hospital based clinic, hospital emergency room, acute hospital inpatient (except when provided as part of hospice care) and bed hold for an individual who is presumptively eligible for coverage of nursing facility services.	No Resource Test	N	N
Limitations or Non covered depending on Buy In Indicator	D	09	MEDICARE CO-INSURANCE & DEDUCTIBLE ONLY	Coverage for Medicare deductibles and co-insurance amounts for <u>Medicare</u> approved services. No coverage for medical services/supplies.	A (Current)	N	N

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Exclusions (Service Type 54)	B	10	ALL SERVICES EXCEPT NURSING FACILITY SERVICES	Coverage for all Medicaid covered services/supplies except nursing facility services provided in a SNF, ICF or inpatient setting. All pharmacy, physician, ambulatory care services and inpatient hospital services, not provided in a nursing home, are covered.	**D (60 Months) **This type of coverage is provided to individuals determined to have made a prohibited transfer of assets.	Y* *No coverage for ICF/DD	Y
Active Coverage	Y	11	ALIESSA ALIENS	Coverage for State Plan services to legal aliens who entered the US on or after 08/22/96. Previously this group was only eligible for emergency services. Note: This is not Federally Participating Medicaid. However, individuals are eligible for Medicaid coverage of OPWDD Home and Community Based Waiver services.	D (60 Months)	Y	Y
Limitations (Presumptive Eligibility Prenatal A)	I	13	PRESUMPTIVE ELIGIBILITY PRENATAL CARE A	Coverage for medical services except inpatient care, institutional long term care, alternate level care and long term home health care.	No Resource Test	N	N
Limitations (Presumptive Eligibility Prenatal B)	J	14	PRESUMPTIVE ELIGIBILITY PRENATAL CARE B (disabled 10/19/2015)	Coverage for ambulatory prenatal care services excluding inpatient hospital, long term home health care, hospice, alternate level care, ophthalmic services, durable medical equipment (DME), therapy (speech, physical and outpatient), abortion services and podiatry.	Discontinued	N	N

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Limitations (Perinatal Family)	L	15	PERINATAL CARE (disabled 10/19/2015)	Coverage for a limited package of benefits excluding podiatry, long term home health care, long term care, hospice, ophthalmic services, DME, therapy (speech, physical and outpatient), abortion services and alternate level of care.	Discontinued	N	N
Active Coverage	T	16	SAFETY NET (historic only)	Coverage for all Medicaid covered services/supplies.	Discontinued	Y	Y
Non Covered	O	17	HEALTH INSURANCE PREMIUM	Coverage for health insurance premiums only.	A (Current)	N	N
Limitations (Service Type 82)	F	18	FAMILY PLANNING SERVICES ONLY	Coverage for Family Planning Services only. The Family Planning Benefit Program provides Medicaid coverage for family planning services to individuals of childbearing age with gross income at or below 223% of the Federal Poverty Level. Eligible members (male and female) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid. Ineligible for Medicaid payment of inpatient hospitalizations.	No Resource Test	N	N

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Limitations (Community Coverage w/ CBLTC)	1	19	COMMUNITY COVERAGE WITH COMMUNITY BASED LONG TERM CARE	Coverage for most Medicaid covered services/supplies except nursing home services in a skilled nursing facility (SNF) or inpatient setting, managed long-term care in a SNF, hospice in a SNF or intermediate care facility and HCBS Waiver Services. Individual is eligible for one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF. New ARU and MEVS eligibility response message: Community Coverage with CBLTC. Can enroll in Managed Care.	D (Current at Initial) A (at Renewal)	Y* *No coverage for ICF/DD	Y
Limitations (Community Coverage no LTC)	2	20	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	Recipient is eligible for ambulatory care, including prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency (CHHA) services. Can enroll in Managed Care. <u>Excluded:</u> Recipient is ineligible for adult day health care, Assisted Living Program, certified home health agency services other than short-term rehabilitation, hospice, managed long-term care, personal care, long-term home health care, consumer directed personal care assistance program,	A (Current)	N	Y

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				<p>limited licensed home care, personal emergency response system, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting, and waiver services provided under the Long-Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the OPWDD Home and Community-Based Waiver Program.</p> <p>ARU and MEVS eligibility response message: Community Coverage No LTC.</p>			
<p>Limitations (Outpatient Coverage with CBLTC)</p>	3	21	<p>OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE</p>	<p><u>Included:</u> Recipient is eligible for most ambulatory care, including prosthetics, HCBS Waiver Services and one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF.</p> <p><u>Excluded:</u> Recipient is ineligible for inpatient coverage other than short-term rehabilitation in a SNF.</p> <p>Local social services districts will determine eligibility for short-term rehabilitation nursing home care. For recipients determined to be eligible, a "Notice of Intent to Establish a Liability Toward the Cost of Care – Short Term Rehabilitation" will be issued to both the recipient and facility.</p>	D (Current)	<p>Y*</p> <p>*No coverage for ICF/DD</p>	Y

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				New ARU and MEVS eligibility response message: Outpatient Coverage with CBLTC			
Limitations (Outpatient Coverage no LTC)	4	22	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	<p><u>Included:</u> Recipient is eligible for some ambulatory care, including prosthetics, and short-term rehabilitation services. Short-term rehabilitation services include one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, and one commencement of service in a 12-month period of up to 29 consecutive days of certified home health agency (CHHA) services.</p> <p><u>Excluded:</u> Recipient is ineligible for inpatient coverage and adult day health care, Assisted Living Program, certified home health agency except short-term rehabilitation, hospice, managed long-term care, personal care, long-term home health care, consumer directed personal care assistance program, limited licensed home care, personal emergency response system, private duty nursing, nursing home services in a SNF other than short-term rehabilitation, nursing home services in an inpatient setting and waiver services provided under the Long-Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and OPWDD Home and</p>	A (Current)	N	Y

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				Community-Based Waiver Program. New ARU and MEVS eligibility response message: Outpatient Coverage No LTC			
Limitations (Outpatient Coverage no NFS)	5	23	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	<u>Included:</u> Recipient is eligible for all ambulatory care, including prosthetics and HCBS Waiver Service. <u>Excluded:</u> Recipient is ineligible for inpatient services. New ARU and MEVS eligibility response message: Outpatient Coverage No NFS	D (60 Months) Prohibited transfer was made	Y* *No coverage for ICF/DD	Y
Limitations (Community Coverage No LTC)	6	24	COMMUNITY COVERAGE WITHOUT LONG TERM CARE (NYC Only)	FOR USE IN NYC ONLY. Can enroll in Managed Care. The coverage package is the same as Coverage Code 20.	A (Current)	N	Y
Eligible (only Inpatient Services)		25	INPATIENT OMH	Coverage is limited to inpatient hospital stays for individuals who are 21-64 years of age and residing in a psychiatric center.	NA	N	N
Eligible (only Inpatient Services)		26	INPATIENT PRISONER	This coverage is for incarcerated individuals. Coverage is limited to inpatient hospital stays for individuals who are incarcerated in a New York State or local correctional facility. Outpatient services, such as emergency room and observation that do not result in an inpatient stay, are not covered.	NA	N	N

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Limitations		27	FAMILY PLANNING EXTENSION PROGRAM	Provides 24 months of family planning services for women who are pregnant while in receipt of Medicaid and subsequently not eligible for Medicaid or FHP due to failure to renew or who do not have US citizenship or satisfactory immigration status, or who have income over 223% of the Federal Poverty Level. This coverage begins once the 60 day postpartum period of coverage ends. Eligible members (females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid except for transportation.	No Resource Test	N	N
Managed Care Coordinator	P	30	PCP FULL COVERAGE (MANAGED CARE) *There is Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC)	Coverage under a Prepaid Capitation Plan (PCP). The individual is PCP eligible as well as eligible for limited fee-for-service benefits.	Attest Unless Requesting Long Term Care	Y* MMC covers HCBS Waiver and ICF/DD. MLTC does not.	Y* MMC covers MSC. MLTC does not.
Other or Additional Payer *Note: See Medicaid Managed Care Section ("If name of Health Plan is other than FHP")	G	31	PREPAID CAPITATION PLAN (PCP) COVERAGE ONLY (disabled 10/21/2013)	Coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the individual becomes ineligible for Medicaid services. No coverage for medical services/supplies. Coverage is solely for services that are covered in the PCP plan.	Discontinued	N	N

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Managed Care Coordinator	Q	32	PCP/SAFETY NET (historic only)	Safety Net recipient covered under a Prepaid Capitation Plan (PCP). The individual is PCP eligible as well as eligible for limited fee-for-service benefits (carved out benefits i.e. MSC).	Discontinued	Y	Y
Other or Additional Payer	R	33	PCP GUARANTEE/ SAFETY NET (historic only) (disabled 10/21/2013)	Safety Net recipient coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the individual becomes ineligible for Medicaid services. No coverage for out of plan medical services/supplies.	Discontinued	N	N
Other or Additional Payer *Note: See Medicaid Managed Care Section ("Family Health Plus")	U	34	FAMILY HEALTH PLUS (FHPlus) (disabled 1/1/2015)	Covered for comprehensive benefits package provided through managed care organizations for adults with and without children who have income or resources greater than the current Medicaid standards. <u>Not</u> Medicaid Fee for Service coverage.	Discontinued	N	N
Other or Additional Payer	W	36	FAMILY HEALTH PLUS GUARANTEE (disabled 1/1/2015)	Coverage for FHP premiums only. The FHP plan provider is guaranteed the capitation rate for a period of time after the individual becomes ineligible for FHP services. No coverage for out of plan medical services/supplies.	Discontinued	N	N