

**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 (36-60 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.	D (36-60 Months)	Y* *No coverage for ICF/DD	Y
	X	03	CATASTROPHIC	Historical only; no longer valid coverage	NA	N	N
Non Covered	N	04	NO COVERAGE INELIGIBLE	Not covered for Medicaid services	NA	N	N
Non Covered	K	05	SANCTIONED		NA	N	N
Spenddown	V	06	PROVISIONAL-EXCESS INCOME	Not covered for Medicaid services until a spenddown 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 medical services except hospital based clinic, hospital emergency room, hospital inpatient and residential health care 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
Exclusions (Service Type 54)	B	10	ALL SERVICES EXCEPT LONG TERM CARE	Coverage for all Medicaid covered services/supplies except Long Term Care services (i.e. Nursing Home and ICF room & care)	**D (36-60 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

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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 OMRDD Home and Community Based Waiver services.	D (36-60 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	Coverage for ambulatory prenatal care services excluding inpatient hospital, long term care, hospice, alternate level care, ophthalmic services, durable medical equipment (DME), therapy (speech, physical and outpatient), abortion services and podiatry	No Resource Test	N	N
Limitations (Perinatal Family)	L	15	PERINATAL CARE	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	No Resource Test	N	N
Active Coverage	T	16	SAFETY NET	Coverage for Medicaid covered services/supplies	Will be 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	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 all 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. Client 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	<p>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.</p> <p><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, 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</p>	A (Current)	N	Y

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				<p>waiver services provided under the Long-Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.</p> <p>ARU and MEVS eligibility response message: Community Coverage No LTC.</p>			
Limitations (Outpatient Coverage with CBLTC)	3	21	OUTPATIENT COVERAGE WITH COMMUNITY BASED LONG TERM CARE	<p><u>Included:</u> Recipient is eligible for all 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> <p>New ARU and MEVS eligibility response message: Outpatient Coverage with CBLTC</p>	D (Current)	Y* *No coverage for ICF/DD	Y
Limitations (Outpatient Coverage no	4	22	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	<p><u>Included:</u> Recipient is eligible for most ambulatory care, including prosthetics, and short-term rehabilitation services. Short-</p>	A (Current)	N	Y

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LTC)			<p>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 the Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.</p> <p>New ARU and MEVS eligibility response message: Outpatient Coverage No LTC</p>			

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Limitations (Outpatient Coverage no NFS)	5	23	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	<p><u>Included:</u> Recipient is eligible for all ambulatory care, including prosthetics and HCBS Waiver Service.</p> <p><u>Excluded:</u> Recipient is ineligible for inpatient services.</p> <p>New ARU and MEVS eligibility response message: Outpatient Coverage No NFS</p>	D (36-60 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.	A (Current)	N	Y
Managed Care Coordinator	P	30	PCP FULL COVERAGE (MANAGED CARE)	Coverage under a PCP. The person is PCP eligible as well as eligible for limited fee-for-service benefits. *There is Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC).	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 PROGRAM (PCP) COVERAGE ONLY	Coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the person becomes ineligible for Medicaid services. No coverage for medical services/supplies. Coverage is solely for services that are covered in the PCP plan.	Attest Unless Requesting Long Term Care	N	N
Managed Care Coordinator	Q	32	PCP/SAFETY NET	Safety Net recipient covered under a PCP. The person is PCP eligible as well as eligible for limited fee-for-service benefits (carved out benefits i.e. MSC).	Attest Unless Requesting Long Term Care	Y	Y

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Other or Additional Payer	R	33	PCP GUARANTEE/ SAFETY NET	Safety Net recipient coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the person becomes ineligible for Medicaid services. No coverage for out of plan medical services/supplies.	Attest Unless Requesting Long Term Care	N	N
Other or Additional Payer *Note: See Medicaid Managed Care Section ("Family Health Plus")	U	34	FAMILY HEALTH PLUS (FHPlus)	Covered for comprehensive benefits package provided through managed care organizations for adults with and without children who have incomes or assets greater than the current Medicaid standards. <u>Not</u> Medicaid Fee for Service coverage	A (Current)	N	N
	W	36	FAMILY HEALTH PLUS GUARANTEE	Coverage for FHP premiums only. The FHP plan provider is guaranteed the capitation rate for a period of time after the person becomes ineligible for FHP services. No coverage for out of plan medical services/supplies.	A (Current)	N	N