

Family Health Plus Co-Pay Questions and Answers

Emergency Services

Is there a \$5 co-pay for physician services on emergency visits?

No, there is no co-payment for emergency services.

Is there a copay for an emergency visit at a physician office?

No, there is no co-payment for emergency services regardless of where the service is rendered.

When a member goes to the ER, he/she will probably be assessed a \$3 co-pay. How is it determined that the “prudent layperson” rule has or has not been met? How does the member get his/her \$3 co-pay back if it was a legitimate visit?

Hospitals ERs should not automatically assess a \$3 co-pay in every instance. If the facility determines the visit is non-emergent and intends to bill the plan the triage fee, the \$3.00 co-payment should be collected. If the facility determines the ER visit was appropriate and intends to bill the plan for an ER visit, no co-payment would be collected as emergency services are exempt.

For ER services, the \$3 co-payment applies for non-urgent and non-emergency services. If a physician group bills for their services separate from the hospital for the ER visit, should the \$3 co-payment be applied to both (one for the hospital ER and the other for the physician component in the ER)?

Only one non-urgent ER co-payment would apply and it would be applicable to the facility component.

Services Rendered Outside New York State

What is the procedure for co-payments when a member receives services out of state? The provider is not bound by NYS law and therefore would be able to refuse services if the member couldn't pay the copay.

In emergency situations, no co-payment is required. Since care must be authorized by the plan for non-participating providers, most out of state care will probably be for emergency services for which there is no co-payment. In any event, applicable co-payments are the responsibility of enrollees when they see out of state providers.

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Services Provided During Physician Office Visits

If a member goes to the doctor for an allergy injection, what copay applies? The physician sometimes bills for an office visit and sometimes just for the injections. This would also be applicable to chemotherapy.

One physician visit co-payment would apply since both the visit and the injection are considered physician services.

Members Turning 21

When a member turns 21 and is no longer in the exempt category, do co-pays go into effect on their 21st birthday or at the end of the month in which they turn 21?

Copays go into effect on a member's 21st birthday.

Pregnancy

Does the 60 day postpartum period apply to miscarriage and terminations?

The 60 day post partum period applies to all pregnant women, including those who deliver still-born babies, miscarry or terminate their pregnancies. The rule is in effect for 60 days after the pregnancy ends.

Options for pregnancy verification include:

- **Member self-declaration**
- **Documentation from a prenatal care provider (i.e. test results, reports, prescriptions, etc.)**
- **Documentation of an order for a pregnancy-related drug or service (e.g.: prenatal vitamins)**
- **Documentation that a prescription/order was made by a prenatal care provider**

Hospitalization

A member is admitted to a hospital and has surgery. Sometimes, the surgery is billed separately. Would the member have a separate copay for the surgery?

Only one \$25 co-payment should be assessed per inpatient hospital stay.

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A member is admitted to a hospital. The member is later transferred to another inpatient facility. To whom does the member owe a co-pay?

When a patient is transferred to another facility for specialty or continuing care, a co-payment should be collected by the hospital that discharges the member from inpatient care—that is, the second hospital.

Clinic Services

If a member goes for hemodialysis (or cardiac rehabilitation, or chemotherapy and radiation), would the clinic co-pay apply?

The clinic co-payment applies to the professional component delivered in the clinic, e.g. physician visit. Other services delivered in the clinic setting that do not have a co-payment associated with them, would not have a co-payment.

Vision

If an ophthalmologist is treating a medical condition, it is considered a physician service and a co-pay would apply. If he/she is providing refractive services/eyewear there is no co-payment, as the service is considered a vision care service.

Would the allowable one self-referral to an optometrist or ophthalmologist for refractive services in a 24 month period count as the one routine vision care for glasses, contacts, and/or occupational glasses in the same 24 month period?

Yes.

Do the limitations on the vision benefit apply to 19 and 20 year olds too? If FHP members are covered by the Child/Teen Health Program, can their access to exams, eyeglasses, and other services be limited?

FHP members who are under 21 are covered by the Child/Teen Health Program (or EPSDT) requirements and as such would not be subject to the new limitations.

Pharmacy

What is included in sick room supplies?

Sick room supplies are those covered medical supplies in the FHP benefit package: diabetic supplies (e.g.: test strips, glucose monitors, lancets, syringes), hearing aid batteries, and enteral formulae.

What is the definition of a prescription under the new regulations?

The MMIS Pharmacy Provider manual provides a detailed definition. Prescription and non-prescription drugs, and medical and surgical supplies may be ordered by

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physicians, podiatrists, dentists, nurse practitioners and registered physician assistants (with some limitations and/or special requirements).

Although medical supplies and OTCs do not require a prescription per se, many prescribers use their prescription blanks to write fiscal orders for these items.

Which drugs do not require a co-payment?

Psychotropic drugs, drugs to treat tuberculosis and family planning prescriptions do not require a co-payment.

Are there discounts permitted if the member orders prescriptions through a mail order service?

No. The same co-pays would apply regardless of whether the prescription is obtained at a retail pharmacy or through mail order.

Are there higher co-pays for non-formulary prescriptions?

The only distinction in the co-pay charged for prescription drugs is between generic and brand name drugs.

The examples of medical supplies listed in the materials sent to plans are mostly diabetic supplies. What about diabetic supplies purchased through a PBM?

The co-payment is on covered medical supplies. FHP covered medical supplies include only: diabetic supplies (e.g.: test strips, glucose monitors, lancets, syringes), hearing aid batteries, and enteral formulae. There is no co-payment for DME. Diabetic supplies purchased through a PBM are subject to co-payment.

Clinic/Outpatient Hospital Visits

When a member visits a clinic and their physician calls a co-physician within the group and requests they immediately look at the member, does this second “visit” require a co-pay also?

If a claim or encounter is reported by each, a co-pay would apply to each. If the second physician provides a casual consultation that wouldn’t result in an additional claim or encounter reported to the plan, then no co-pay should be charged.

Physician Services

The physician co-payment would apply when a patient sees either a nurse practitioner or physician assistant who acts as a physician extender providing physician services.

Mental health services are exempt from co-payments regardless of the licensure of the individual providing the service.

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Chiropractic services are not covered under FHP. The radiology co-payment of \$1 would apply when the member receives a radiology service. If a podiatrist is treating a medical condition it is considered a physician service and a co-pay would apply.

Does the co-pay for physician visits include inpatient consults by physicians?

If a separate claim or encounter is reported, the physician co-pay would be applicable.

Does the physician office visit co-pay cover the cost of preventive services (such as pap smears, mammogram, prostate cancer screening, etc) or is there separate co-pay?

The physician co-payment applies to the services that are included in the code billed for an office visit or consultation (often identified by CPT codes). Additional lab tests or radiology services billed separately by the physician are also subject to the applicable co-payment even if done during the same visit. So, for example, a separate co-payment would apply to a Pap smear, mammogram and prostate cancer screening.

Are there co-pays on ambulatory surgery in a physician's office?

A \$5 co-payment would apply to the physician's service.

Dental

Is the dental co-pay per visit or per service?

The co-pay is per visit. A separate co-payment is not charged for any x-rays taken during the dental visit.

Dental Service Visits – Is the \$25 cap based on calendar year, benefit year or 12 month period?

Calendar year.

If the dental co-pay is charged on a service visit, is "service" defined as any type of service or anything but routine or preventive?

A co-payment is charged for any visit EXCEPT an emergency visit, up to the annual yearly cap of \$25.

Is the dental cap based on co-pays billed/requested or co-payments collected?

The \$25 annual cap is based on the co-payments billed/requested.

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How can co-payments be tracked if the individual has not been in the plan for 12 months?

A plan is only responsible for tracking co-payments for the period during which the member is enrolled in their plan. Members who switch plans during the calendar year will be responsible for documenting to the plan that they had previously satisfied all or part of their annual deductible while enrolled in another plan during the calendar year.

How is emergency dental service defined?

Emergency Services are defined as care provided after a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could reasonably result in serious impairment of bodily functions, serious dysfunction of a bodily organ or body part or would otherwise place the recipient's health in serious jeopardy.

Inpatient Hospital

If a member is discharged from the hospital, is there a specific period of time within which if the member is readmitted, the member would not have an additional co-pay?

If the subsequent hospital stay is considered a separate admit and discharge, an additional inpatient co-payment would be required.

Inpatient claims – Is a pregnant member subject to co-pays for any inpatient services, e.g., those unrelated to pregnancy?

No. A pregnant woman is categorically exempt from all co-pays, not just co-pays for maternity services.

Does the co-payment for an inpatient stay refer to all inpatient stays including psychiatric stays and skilled nursing facilities (SNFs)?

The inpatient co-pay applies to all inpatient stays in a general hospital. There is no co-pay on SNF or residential health care facility (RHCF) services.

The co-payment for an inpatient stay should not be applied for hospital stays related to emergency conditions. Does this mean we should not apply a co-payment for any admission via the emergency room?

There would be no ER co-payment; however the inpatient stay would be subject to the \$25 inpatient co-payment upon discharge.

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Should a co-pay be applied for a 23-hour stay? Example: Patient admitted at 10:30 pm on August 2nd and discharged at 9:30 am on August 3rd. Should the patient be charged a co-pay for a 23 hour stay when they are not really an inpatient?

An inpatient co-payment should be charged if the hospital bills for an inpatient stay.

Behavioral Health

Are all outpatient mental health / chemical dependence visits exempt from co-pays or only those provided by certain provider types (e.g., Article 28 clinics, Article 31 facilities) or specific services?

All outpatient behavioral health services are exempt from co-payments, regardless of setting or provider.

Residential Health Care Facility (RHCF)

Is a member in a skilled nursing facility (SNF), who is not a permanent resident subject to any co-payments?

A person receiving care in a SNF or RHCF is not exempt from co-pays unless he/she is a permanent resident.

Multiple Services

If a member has more than one visit on the same day, do multiple co-pays apply (i.e., one for each visit)? Is there a maximum co-pay that can be assessed during one day (i.e., if the person visited the ER (\$3) and a physician (\$5) on the same day, would the co-pay maximum be \$5 for the day or should the member pay a total of \$8 co-pays?

Yes, a co-pay would apply to each service that requires a co-payment. There is no maximum daily co-payment.

If a member has more than one service during the same visit, do multiple co-pays apply (i.e., one for each service for which a co-pay is applicable)?

Yes, co-pays would apply to each service that requires a co-payment.

Second Surgical Opinion

Do second opinion visits prior to surgery require a co-pay?

Yes.

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Family Planning

If a member receives family planning services as part of an OB/GYN clinic or physician visit, is the visit co-pay exempt?

Yes. Family planning services and supplies are exempt from co-pays regardless of setting.

Family planning services do not have co-pays. What about foam, condoms, etc?

Contraceptive foam and condoms are examples of over-the-counter products not covered by FHP.

Radiology/Lab Tests

Do co-pays apply for radiology services in an urgent care center? If yes, what is the required co-pay amount?

Yes, the radiology co-pay amount(s) (\$1.00 for each CPT code billed) would apply.

If a lab test is collected by a physician (and the physician does not bill for the lab test) and it is sent to a reference lab, how is the reference lab to collect the co-pay as there is no contact between the lab and the member?

The laboratory would send the patient/recipient a bill in the mail after reimbursement was received from the plan.

Is there a co-pay on the professional component of an x-ray which is taken in the Emergency Room or when member is confined as an inpatient?

There is no co-payments for emergency services, unless the ER service is not an emergency, then there is a single \$3 co-payment. Likewise, for an inpatient stay, there would only be a single \$25 co-payment, payable upon discharge.

What happens when a plan “re-bundles” tests that a lab has billed separately and the lab has charged a co-payment for each lab test?

All lab billing is done by CPT code. There is one 0.50 co-pay for each CPT code billed to the plan.

Member ID Cards

The Health Plus Member ID card for Family Health Plus will be updated to include the co-pays in effect for physician office visits and for brand name and generic drugs.

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Billing for co-pays

Are providers (physicians, pharmacies, etc.) *required* to bill when they have failed to collect a co-pay because the member is “*unable to pay*”? May the provider waive the co-pay?

It is the responsibility of the provider to collect the co-pay, however they are not required to bill the patient when the patient is unable to pay at the time of service.

Can providers use a collection agency? What happens if the member refuses or is unable to pay the co-pay?

Providers may bill for co-pays and use other legal means to collect applicable unpaid co-pays. However, providers may not withhold covered services based on the inability of an enrollee to pay an applicable co-pay.

In additions, providers may not bill Health Plus for the co-payments not collected from members.

Is any reporting affected by the co-pays, e.g. MMCOR or MEDS?

No.

Should the co-pay amount for urgent care centers be \$5 (physician visit) or \$3 (non-urgent ER)?

The \$5 physician or clinic co-pay would apply.