The Utilization Threshold Program

1. **What is the UT program?**

   The Utilization Threshold (UT) program places limits on the number of services a Medicaid beneficiary may receive in a benefit year. A benefit year is a 12-month period, which begins the month in which the beneficiary becomes Medicaid eligible.

2. **What are the limits on the services?**

   The Service Limits are as follows:

Physician / Clinic	Beneficiary-specific
Laboratory	Beneficiary-specific
Pharmacy *	Beneficiary-specific
Mental Health Clinic	Beneficiary-specific
Dental Clinic	Beneficiary-specific

   * **Each pharmacy refill is counted in service limits.**

   A service authorization (SA) must be obtained for each refill on new and existing prescriptions.

   Each Medicaid beneficiary is assigned specific service limits for Physician/Clinic, Laboratory, Pharmacy, Mental Health Clinic and Dental Clinic services. These service limits are scientifically established based on each beneficiary's clinical information, including diagnoses, procedures, prescription drugs, age and gender. As a result, most Medicaid beneficiaries have clinically appropriate service limit levels and will not need additional services authorized through the Threshold Override Application (TOA) process. Beneficiary-specific service limits significantly reduce the need for, and the number of, TOAs.

3. **How is a UT related to claim payment?**

   A UT service authorization is required prior to payment of claims for providing services included in the UT program. CSC matches the information listed in question 4 below with the appropriate provider claim data to pay the claim.

4. **What UT service authorization information does CSC require for claim payment?**

   In order to provide claim payment, CSC will match the provider claim to the UT service authorization, and then compare the following information:

   - Beneficiary Identification Number
   - Date of Service
   - Provider Identification Number

5. **How does a provider obtain a service authorization?**

   Providers must obtain a UT service authorization via the **Medicaid Eligibility Verification System (MEVS)**, which is operated by CSC. UT service authorizations are obtained through MEVS via:

   - ePACES
   - Verifone Card-Swipe Terminal
   - CPU (HIPAA 278)
   - Touch tone telephone, at (800) 997-1111

   To obtain a Verifone, information on methods of alternate access or for assistance with ePACES enrollment or ePACES eligibility screens contact the eMedNY Call Center at **(800) 343-9000**.

6. **Who should be called for UT service authorization instructions?**

   Call CSC at **(800) 343-9000** for assistance in obtaining service authorizations, or for help with any other MEVS-related questions or refer to the MEVS manual at **www.emedny.org**

7. **Is a UT service authorization needed when billing for secondary claims?**

   The requirement for a UT service authorization does not change because of the involvement of Medicare or other insurance.

8. **Are there conditions where it may be necessary to obtain another service authorization for the same claim?**

   UT service authorizations remain on file for 120 days for non-Pharmacy providers. Therefore, if the UT ages off the system, it may be necessary to obtain another service authorization if a claim must be resubmitted or submitted after billing Medicare or other insurance.

9. **How do group practice providers secure UT service authorizations?**

   MEVS allows a physician group-practice to secure a UT service authorization using the group provider ID number when it is not known which doctor will perform the service. If the UT was issued to the group provider ID number, the resulting claim must be billed under the group ID number.

   NOTE: Service authorizations created under an individual physician ID are applicable only for that physician.

10. **How does a provider know if a service authorization has been secured?**

    The entire MEVS message must be heard (or read) to determine the status of the requested service authorization. There are four possible telephone messages, which are as follows:

    - "Service Approved UT" (authorization approved)
    - "Approved Near Limit" (authorization approved)*
    - "At Service Limit" (no authorization approved)*
    - Partial Approval-for Labs (received only a portion of what was requested)

There are five possible ePACES and Verifone HIPAA compliant messages which are as follows:

- A1: Approved in Full: All requested Service(s)/Units authorized
- A3: Denied: Requested Service(s)/Units not authorized
- A6: Approved with Modification: Some portion of requested Service(s)/Units authorized (Beneficiary may not have sufficient Units left to fulfill request.)
- CT: Contact Payer (contact the payer for additional information)
- NA: No Action Required (Authorization unnecessary for service requested)

NOTE: Laboratory and pharmacy providers should refer to their MEVS or Pharmacy ProDur/ECC manual for specific information about MEVS messages.

11. When may a provider bill after receiving service authorization approval?

UT service authorizations are available immediately. There is no need to delay billing.

NOTE: No service authorization number is assigned.

12. When are UT Service Authorizations not required?

UT Service Authorizations are not required for Medicaid Managed Care beneficiaries, beneficiaries in the Managed Care Guarantee Programs and other specially designated beneficiaries except for services, which require a Pharmacy Service Authorization.

13. What happens to a claim if no service authorization is found?

If a UT service authorization record is not on file at the time a claim is initially processed, the claim will pend for edits 01154 or 01155 - "No UT Service Authorization On File" or "UT Exhausted" respectively. Claims pending for these reasons will pend for 60 days (from the date of the remittance on which the first pend appeared). If the provider obtains the UT service authorization, the UT service authorization will be found during the claim recycling process and the claim will be paid in a subsequent remittance statement.

Do not resubmit pending claims!

NOTE: Remittance statements are held for approximately two weeks prior to mailing. Therefore, providers will not see claims change from pending to paid status for at least three subsequent remittance statements.

A claim will deny if a UT service authorization record is not on file by the end of 60 days. At that time, if the claim denies for "No UT Service Authorization On File" the provider may obtain a UT service authorization and resubmit the claim. If the beneficiary has no more service units available, a Threshold Override Application must be submitted by the beneficiary's practitioner to request an increase in service units. If the request is approved, the provider must then obtain a service authorization for the remaining units and if the claim has since denied, resubmit a new claim.

NOTE: Providers receiving a HIPAA compliant electronic 835 remittance will have claims pended, indicated as follows:

- Claim Adjustment Reason Code 15 – "Payment adjusted because the submitted authorization number is missing or invalid"
- Remittance Advice Remark Code N54 – "Claim information is inconsistent with pre-certified/authorized services"

14. **What are the options if a beneficiary is at his/her service limit, and an authorization cannot be obtained, or if a provider's specialty code indicates that the service is exempt from the UT service authorization program?**

If applicable, providers should designate the appropriate exception code in the correct field as noted in the table:

Claim Type	Field / Location
HCFA 150001	Field 25D
837 I & P	Loop 2300 Ref 02
Pharmacy	Field 420-DK

SERVICES EXEMPT FROM THE UT PROGRAM

PHYSICIAN SERVICES:
- Anesthesiology
- Pediatric
- Psychiatric
- Preferred Physicians and Children Program (PPAC)
- Therapeutic Radiology
- Managed Care
- HIV Enhanced Fee for Physicians (HIV-EFP)
- Child Teen Health Program (CTHP)
- Methadone Maintenance Treatment Program (MMTP)
- Medicaid Obstetrical and Maternal Services (MOMS)
- Critical Care
- Dialysis
- Certain services related to pregnancy (Ex. Pre and Post Natal Care)

OTHER:
- Abortion
- Family Planning Services
- Services requiring Prior Approval/Prior Authorization
- Services provided while beneficiary is:
  An inpatient in an acute care hospital
  A resident in a residential health facility
  A patient at a military treatment facility
  When EMEVS displays an Exception Code
  of: 35, 38, 46, 47, 48, 50, 51, 62, 72 & 81.

CLINIC SERVICES:
- Pediatric General Medicine and Specialties
- Mental Health Continuing Day Treatment Programs
- Mental Health Continuing Treatment
- Alcohol Treatment Programs
- Child Teen Health Program (CTHP)
- School Supportive Health Services Program
- Hemodialysis
- Methadone Maintenance Treatment Program (MMTP)
- Oncology
- OMR/DD Clinic Treatment and Specialty Programs
- TB/DOT
- Prenatal Care

LABORATORY SERVICES:
- Drug Screen
- Pap Smear

*Exempt MEVS Exception Codes:
See Exception Codes listed in the MEVS manual found at **www.emedny.org** under **Manuals**

Specialty Codes Exempt from Service Authorizations

020, 130, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 161, 169, 186, 191, 192, 193, 196, 205, 247, 249, 270, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 312, 313, 314, 317, 318, 319, 320, 323, 325, 750, 798, 900, 904, 906, 907, 908, 912, 913, 918, 922, 934, 936, 937, 938, 939, 940, 941, 942, 943, 944, 949, 959, 960, 961, 962, 967, 968, 969, 972, 973, 975, 976, 977, 978, 979, 980, 981, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998

SERVICE AUTHORIZATION EXCEPTION CODES

The following table lists all of the Service Authorization Exception Codes currently in use by NYS Medicaid today.

HIPAA Code	HIPAA Description
1	Immediate/urgent
2	Services Rendered in Retroactive Period
3	Emergency Care
4	Beneficiary Has Temporary Medicaid
5	Request from County for 2nd Opinion to Determine if Beneficiary Can Work
6	Request for Override Pending
7	Special handling

Although providers no longer report their specialty code on claim transactions, specialty codes continue to be used internally to process claims. NYS Medicaid has implemented the use of the additional HIPAA Service Authorization (SA) Exception Code for the handling of Utilization Threshold exempt claims. Code 7 - Special handling must be reported in place of your previously reported exempt Specialty Codes.

For further information on taxonomy and service types refer to the MEVS Manual which may be downloaded from **www.emedny.org**.

- click on "Provider Manuals"
- click on "MEVS Provider Manual"

Section 13.1 through 13.2 contains taxonomy and service type codes

When a beneficiary is at his/her service limit, and an authorization cannot be obtained, or if a provider's specialty code indicates that the service is exempt from the UT service authorization program, providers should designate the appropriate exception code in the correct field as noted below:

Claim Type	Field / Location
HCFA 150001	Field 25D
837 I & P	Loop 2300 Ref 02
Pharmacy	Field 420-DK

Services Subject To The UT Program

All COS/Specialties on the list below are considered subject to the Utilization Threshold Program and require a Service Authorization. If you have questions regarding whether a service is exempt, you may call CSC at 800-343-9000.

DESCRIPTION	Category of Service (COS)	SPECIALTY CODES
PHYSICIAN	0460	010, 030, 040, 041, 050, 060, 062 THRU 070, 080, 089, 092, 093, 100, 110, 120, 131, 135 THRU 139, 141 THRU 143, 146, 148, 160, 170, 181 THRU 185, 194, 200 THRU 202, 210, 220, 230, 241, 242, 250, 402 THRU 404
MENTAL HEALTH CLINIC	0160, 0287	310, 311, 315, 316, 322, 945 THRU 948, 963, 964, 971, 974
CLINIC	0160, 0287	321, 901, 902, 903, 905, 909, 914 THRU 917, 919 THRU 921, 923 THRU 933, 935, 950 THRU 958, 965, 966, 999
PHARMACY	0160, 0288, 0441	N/A
DENTAL CLINIC	0160, 0287	910 AND 911
LABORATORY	0162, 0281, 1000	400 THRU 599

Specialty codes need to be entered only if using the non-HIPAA compliant ARU. HIPAA compliant MEVS process requires the entry of a Service type and/or Taxonomy Code.

For further information on taxonomy and service types refer to the MEVS Manual which may be downloaded from **www.emedny.org**.

- click on "Provider Manuals"
- click on "MEVS Provider Manual"

Section 13.1 through 13.2 contains taxonomy and service type codes

Providers who have questions about what specialty codes they have on file may contact the eMedNY Call Center at 1-800-343-9000. The Call Center Representative may be able to give that information over the phone. In cases where the provider has too many specialty codes to be given over the telephone, the provider will be directed to request the specialty code list in writing.

Medicaid Override Application System (MOAS)

What are TOAs?

The Utilization Threshold (**UT**) program limits the number of times Medicaid beneficiaries can receive certain medical services in a benefit year. Increases in a beneficiary's UT service limits can only be granted upon submission of a Threshold Override Application (**TOA**). Beneficiaries are informed of the need to have a TOA submitted via a "nearing limits" letter.

NOTE: Increases in service limits may only be requested for the beneficiary's current benefit year.

Whom do providers contact to request TOAs?

- Providers should call CSC at **(800) 343-9000** to request TOAs.
- Completed paper TOA forms (EMEDNY 000104) should be sent to CSC for processing:

  Computer Sciences Corporation, PO Box 4602, Rensselaer, N. Y. 12144-4602

INSTRUCTIONS FOR COMPLETING
THE EMEDNY 000104 THRESHOLD OVERRIDE APPLICATION FORM

NOTE: Only original Threshold Override Application forms will be accepted

SECTION 1 – BENEFICIARY INFORMATION

1. **Beneficiary ID Number** – Enter the 8-character Beneficiary ID number of the Beneficiary. The first 2 characters are alpha, the next 5 are numeric and the last 1 is alpha.

2. **Beginning Month of Benefit Year** – Enter the beginning month of the Beneficiary's benefit year. This information is returned to the Provider as the Anniversary Month in the MEVS response and is also given in Warning and At Limit letters sent to the Beneficiary.

3. **Last Name/First Name/Middle Initial** – Enter the Beneficiary's last name, first name and middle initial (in that order).

4. **Street Address/City/State/Zip Code** – Enter the Beneficiary's street address. This is the address the system uses to generate a response letter.

5. **City** – Enter the Beneficiary's city.

6. **State** – Enter the Beneficiary's state.

7. **Zip Code** – Enter the Beneficiary's zip code.

8. **Sex** – Place an X over M for male or over F for female to indicate the Beneficiary's sex.

9. **Birth Date** – Enter the Beneficiary's date of birth in month/day/full year (MM/DD/YYYY) format.

SECTION 2 – PROVIDER INFORMATION

1. **NPI Provider ID** – Enter the 10-digit NPI Provider ID number if enrolled in the Medicaid Program. If the Provider is not enrolled, they should leave this field blank.

2. **License Number** – Providers not enrolled in the Medicaid Program can enter their License Number in this field. (You must complete the Profession Code when entering a License number in this field). If a NY State License Number is used, it must be preceded by 2 zeros (or 0F for Nurse Practitioner/Midwife). If an out of state License Number is used, it must be preceded by a valid 2-character alpha state code.

3. **Profession Code** – If a License number is entered because the Provider does not have an NPI Provider ID, the 3-digit profession code must be entered. The profession code identifies the profession assigned to the license number. Profession codes are 3 digits – do not enter "MD" in this **field or the TOA form will be rejected.**

   - Profession Codes can be found at **www.eMedNY.org**

     choose the **NYHIPAADESK** option from the menu
     click on Crosswalks
     click on NYS Medicaid License and Profession Code Table

4. **Last Name/First Name/Middle Initial** – Enter the Provider's last name, first name and middle initial (in that order).

5. **Correspondence Address/City/State/Zip Code** – Enter the Provider's full correspondence address. This is the address the system uses to generate a response letter.

6. **Area Code/Phone/Extension** – Enter the Provider's telephone number with the area code and any applicable extension.

TOA WILL NOT BE ACCEPTED WITHOUT A MEDICAL ASSESSMENT - A written medical assessment must be provided when additional services are requested. The Provider is required to supply medical documentation to justify the increase. Without a medical assessment the request will be returned to the originating provider for the appropriate documentation.

SECTION 3 – MEDICAL DATA

1. **Did beneficiary receive letter?** - Place an X over Y for Yes or over N for No to indicate if the Beneficiary received an At Limits letter. If unknown, leave blank.

2. **Diagnosis Codes** – This field is used to indicate diagnosis codes that describe the Beneficiary's condition. You must enter at least one diagnosis code, and can enter up to 6 codes if necessary. ICD-9-CM codes are used to describe a medical condition. ICD-9-CM codes can be found in the ICD-9-CM book of diagnosis codes.

For **Dental services**: In lieu of diagnosis codes, the Dental codes (listed below) must be used for all TOAs submitted to request an increase in Dental Clinic visits. The Dental codes describe the type of treatment required and are as follows:

Diagnostic	D0100
Preventative	D1000
Restorative	D2000
Endodontics	D3000
Prosthodontics	D4000
Prosthodontics, removable	D5000
Maxillofacial	D5900
Prosthodontics	D6000
Prosthodontics, fixed	D7000
Oral Surgery	D8000
Orthodontics	D9000

3. **Amount of Increase** – Enter the number of additional services being requested for the Beneficiary in the appropriate category. Provide the required written medical assessment. Only 2-digit entries are accepted. To request an exemption in a particular category, enter 99.

4. **Duration of Need** – Enter the number of months the Beneficiary will require the increased number of services. If the need is life long, enter 99.

SIGNATURE - The TOA form must have an original **requesting provider** signature and date. Rubber stamps, photocopies and carbon-copied signatures will **not** be accepted. **Please print name under signature to assist with any follow-up contact.**

PROVIDER INFORMATION: Area Code/Phone/Extension – Please record the Provider's phone number with the area code and any applicable extension. This information is essential to any follow-up contact that may be necessary.

This proof is submitted for your review and approval. It is supplied for content, layout, and version review and does not reflect paper or ink match. Please review your proof carefully.

New York State Department of Health
Medicaid Utilization Threshold Program
Threshold Override Application (TOA)
(please type or print clearly)

I. Member Information

Member ID Number

Beginning Month of Benefit Year

Name in Last Name, First Name, Middle Initial Order

Street Address

City   State   Zip

M   F
Sex   Month   Day   Year
Birth Date

II. Provider Information

Provider Number   or   License Number   Professional Code

Name in Last Name, First Name, Middle Initial Order

Correspondence Address - Line 1

Correspondence Address - Line 2

City   State   Zip

Area Code   Phone   Extension

DESCRIBE MEDICAL CONDITION supporting TOA:

III. Medical Data

1. Did the member receive a letter advising limits had been reached?

Y   N

2. List, in order of importance, the ICD-9-CM Diagnosis Code(s) that warrant, in your judgment, an override of the Medicaid Utilization Thresholds for the remainder of the member's current benefit year.

1.   2.

3.   4.

5.   6.

3. For the service utilization threshold(s) that need to be raised, enter the amount of increase that you suggest for the remainder of the member's current benefit year.

(a) PHYSICIAN/MEDICAL CLINIC ENCOUNTERS
Provide written documentation for all requests

(b) PHARMACY SERVICES
(including prescription drugs, OTC's and medical/surgical supplies) - No. of items
Provide written documentation for all requests

(c) LABORATORY SERVICES - No. of procedures
Provide written documentation for all requests

(d) DENTAL CLINIC VISITS
Provide written documentation for all requests

(e) MENTAL HEALTH ENCOUNTERS
Provide written documentation for all requests

4. How long in months do you expect this condition to last, and the member to need additional service authorizations?

DO NOT STAPLE IN BARCODE AREA

MAIL TO:
CSC
CSC Federal Sector - Civil Group
PO Box 4602
Rensselaer NY 12144- 4602

I hereby certify that, in my professional judgment, the member indicated above should have his/her Medicaid utilization threshold(s) changed as indicated to ensure that proper medical treatment is available without further medical review.

Requesting Provider Signature   Date
Print Name

eMedNY-000104 (2/10)

FACE

New York State Department of Health
Medicaid Utilization Threshold Program
Threshold Override Application (TOA) Instructions

NOTE: Only original Threshold Override Application forms will be accepted.

SECTION I – MEMBER INFORMATION

1. **Member ID Number** – Enter the 8-character Member ID number of the Member. The first 2 characters are alpha, the next 5 are numeric and the last 1 is alpha.
2. **Beginning Month of Benefit Year** – Enter the beginning month of the Member's benefit year. This information is returned to the Provider as the Anniversary Month in the MEVS response and is also given in Warning and At Limit letters sent to the Member.
3. **Last Name/First Name/Middle Initial** – Enter the Member's last name, first name and middle initial (in that order).
4. **Street Address/City/State/Zip Code** – Enter the Member's street address. This is the address the system uses to generate a response letter.
5. **City** – Enter the Member's city.
6. **State** – Enter the Member's state.
7. **Zip Code** – Enter the Member's zip code.
8. **Sex** – Place an X over M for male or over F for female to indicate the Member's sex.
9. **Birth Date** – Enter the Member's date of birth in month/day/full year (MM/DD/YYYY) format.

SECTION II – PROVIDER INFORMATION

1. **MMIS Provider ID** – Enter the 8-digit MMIS Provider ID number if enrolled in the Medicaid Program. This field has been expanded to 10 spaces for NPI implementation by NYS Medicaid. The ID should be entered in the first 8 spaces and the last 2 are left blank. If the Provider is not enrolled, they should leave this field blank.
2. **License Number** – Providers not enrolled in the Medicaid Program can enter their License Number in this field. (You must complete the Profession Code when entering a License number in this field). If a NY State License Number is used, it must be preceded by 2 zeros (or 0F for Nurse Practitioner/Midwife). If an out of state License Number is used, it must be preceded by a valid 2-character alpha state code.
3. **Profession Code** – If a License number is entered because the Provider does not have an MMIS Provider ID, the 3-digit profession code must be entered. The profession code identifies the profession assigned to the license number. Profession codes are 3 digits – **do not enter "MD" in this field or the TOA form will be rejected.**

   • Profession Codes can be found at **www.eMedNY.org**

   choose the **NYHIPAADESK** option from the menu
   click on Crosswalks
   click on NYS Medicaid License and Profession Code Table

4. **Last Name/First Name/Middle Initial** – Enter the Provider's last name, first name and middle initial (in that order).
5. **Correspondence Address/City/State/Zip Code** – Enter the Provider's full correspondence address. This is the address the system uses to generate a response letter.
6. **Area Code/Phone/Extension** – Enter the Provider's telephone number with the area code and any applicable extension.

TOA WILL NOT BE ACCEPTED WITHOUT A DESCRIPTION OF THE MEDICAL CONDITION THAT SUPPORTS THE NEED FOR ADDITIONAL SERVICES.

SECTION III – MEDICAL DATA

1. **Did Member receive letter?** – Place an X over Y for Yes or over N for No to indicate if the Member received an At Limits letter. If unknown, leave blank.
2. **Diagnosis Codes** – This field is used to indicate diagnosis codes that describe the Member's condition. You must enter at least one diagnosis code, and can enter up to 6 codes if necessary. ICD-9-CM codes are used to describe a medical condition. ICD-9-CM codes can be found in the ICD-9-CM book of diagnosis codes.

In lieu of diagnosis codes, the Dental codes (listed below) must be used for all TOAs submitted to request an increase in Dental Clinic visits. The Dental codes describe the type of treatment required and are as follows:

Diagnostic	D0100
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Restorative	D2000
Endodontics	D3000
Prosthodontics	D4000
Prosthodontics, removable	D5000
Maxillofacial	D5900
Prosthodontics	D6000
Prosthodontics, fixed	D7000
Oral Surgery	D8000
Orthodontics	D9000

3. **Amount of Increase** – Enter the number of additional services being requested for the Member in the appropriate category. Provide the required written medical documentation. Only 2-digit entries are accepted. To request an exemption in a particular category, enter 99.
4. **Duration of Need** – Enter the number of months the Member will require the increased number of services. If the need is life long, enter 99.

SIGNATURE – The TOA form must have an original signature and date. Rubber stamps, photocopies and carbon-copied signatures will not be accepted. Please print name under signature to assist with any follow-up contact.

BACK HEAD TO HEAD