GUIDE TO COVERAGE CODES AND HEALTH HOME SERVICES

CODE	ELIGIBILITY BENEFIT	ELIGIBILITY BENEFIT DESCRIPTION	COMPATIBLE WITH HEALTH HOME SERVICES	POLICY NOTES
01	MEDICAID ELIGIBLE	Coverage for all Medicaid covered services/supplies.	**YES**	
02	ELIGIBLE ONLY OUTPATIENT CARE	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. (Spenddown)	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
04	NO COVERAGE – INELIGIBLE OR EP-FAMILY PLANNING AND NON EMERGENCY TRANSPORTATION ONLY	Not covered for Medicaid services.	**NO**	
05	NO COVERAGE – INELIGIBLE	Not covered for Medicaid services.	**NO**	
06	NO COVERAGE: EXCESS INCOME OR NO COVERAGE: EXCESS INCOME, NO NURSING HOME SERVICES, OR NO COVERAGE: EXCESS INCOME, RESOURCES VERIFIED.	Not covered for Medicaid Services until a spenddown of excess income/resources is met.	**YES (See notes)**	Care manager should work with recipients to maintain Medicaid eligibility.
07	EMERGENCY SERVICES ONLY	An emergency is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptom of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any body organ or part. Individuals are allowed to prequalify for coverage for an emergency medical condition by applying using a Medicaid application, prior to the onset of an emergency. Eligible temporary non-immigrants and undocumented aliens are given Coverage Code 07 "Emergency Services Only" coverage for twelve months. Individuals must still have an emergency medical condition in order to qualify for Medicaid payment of care and services provided. Medicaid will not pay for services provided to a temporary non-immigrant or undocumented alien whose medical condition does not meet the definition of an emergency medical condition.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.

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08	PRESUMPTIVE ELIGIBLE LONG TERM/HOSPICE	Coverage for all Medicaid covered services except hospital based clinic, hospital emergency room, acute hospital inpatient (except when providing as part of hospice care) and bed hold for an individual who is presumptively eligible for coverage of nursing facility services.	**NO (See notes)**	Care managers can work with State Health Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
09	MEDICARE CO-INSURANCE & DEDUCTIBLE ONLY	Coverage for Medicare deductibles and co-insurance amounts for Medicare approved services. No coverage for Medical services/supplies	**NO (See notes)**	Care managers should verify eligibility or work with HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
10	ELIGIBLE 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.	**YES**	
11	MEDICAID ELIGIBLE	Coverage for all Medicaid covered services/supplies.	**YES**	
13	PRESUMPTIVE ELIGIBILITY PRENATAL A	Coverage for medical services except inpatient care, institutional long term care, alternate level of care, and long term home health care.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
14	PRESUMPTIVE ELIGIBILITY PRENATAL B	Coverage for ambulatory prenatal care services excluding inpatient hospital, long term care, long term home helath care, hospice, alternate level care, ophthalmic services, DME, therapy (speech, physical and outpatient), abortion services and podiatry.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
15	PERINATAL FAMILY	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 (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
16	MEDICAID ELIGIBLE HR UTILIZATION THRESHOLD	Coverage for all Medicaid covered services/supplies.	**YES**	

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17	NO COVERAGE – INELIGIBLE	Not covered for Medicaid services.	**NO**	
18	ELIGIBLE ONLY FAMILY PLANNING SERVICES	Coverage for Family Planning Services Only. The Family Planning Benefit Program provides Medicaid coverage for family planning services to persons of childbearing age with gross incomes at or below 223% of the federal Poverty level. Eligible members (males and females) have access to all enrolled Medicaid family planning providers and family planning services available under Medicaid.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
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. 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, unlimited CHHA services and waiver and non-waiver services. New ARU and MEVS eligibility response message: Community Coverage with CBLTC. Can enroll in Managed Care.	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
20	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	**Included:** Recipient is eligible for some ambulatory care, including prosthetics, acute inpatient care, care in a psychiatric center 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. **Excluded:** 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,-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, intermediate care facility services, residential treatment facility services and waiver services provided under the Long-Term Home Health Care Program, Traumatic Brain Injury Program, Care at Home Waiver Program and Office for People with Developmental Disabilities (OPWDD) Home and Community-Based Waiver Program.	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.

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21	OUTPATIENT COVERAGE WITH COMMUNITY-BASED LONG TERM CARE	**Included:** Recipient is eligible for most ambulatory care, including prosthetics, one admission in a 12-month period of up to 29 consecutive days of short-term rehabilitation nursing home care in a SNF, unlimited CHHA services, and waiver and non-waiver services. **Excluded:** Recipient is ineligible for inpatient coverage other than short-term rehabilitation in a SNF. 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.	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
22	OUTPATIENT COVERAGE WITHOUT LONG TERM CARE	**Included:** 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. **Excluded:** 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 for People with Developmental Disabilities (OPWDD) Home and Community-Based Waiver Program.	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
23	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	**Included**: Recipient is eligible for all ambulatory care, including prosthetics, and waiver services. **Excluded:** Recipient is ineligible for inpatient services	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.

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24	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	FOR USE IN NYC ONLY. Can enroll in Managed Care. The coverage package is the same as Coverage Code 20.	**YES (See notes)**	Care managers should verify eligibility and coordinate services within coverage limitations, or work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
25	ELIGIBLE ONLY INPATIENT SERVICES	Coverage is limited to I/P hospital stays off the grounds of the psychiatric center	**NO**	
26	ELIGIBLE ONLY INPATIENT SERVICES	This coverage is for incarcerees. Coverage is limited to inpatient hospitalizal stays off the grounds of the correctional facility. Outpatient services, such as emergency room and observation that do not result in an inpatient stay, are not covered.	**NO**	
27	ELIGIBLE ONLY FAMILY PLANNING SERVICES NO TRANSPORTATION	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 FPL. 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 (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.

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CODE	ELIGIBILITY BENEFIT	ELIGIBILITY BENEFIT DESCRIPTION	COMPATIBLE WITH HEALTH HOME SERVICES	POLICY NOTES
30	ELIGIBLE PCP OR ELIGIBLE PCP WITH PHARMACY CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH AND PHARMACY CARVE OUT OR ELIGIBLE PCP WITH FAMILY PLANNING CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH AND FAMILY PLANNING CARVE OUT OR ELIGIBLE PCP WITH MENTAL HEALTH, FAMILY PLANNING, AND PHARMACY CARVE OUT OR ELIGIBLE PCP WITH FAMILY PLANNING AND PHARMACY CARVE OUT	Coverage under a Prepaid Capitation Program (PCP). The client is PCP eligible as well as eligible for limited fee-for-service benefits.	**YES (See notes)**	Care managers should work with members Managed Care Plan to obtain necessary services. **Members in a FIDA, FIDA-IDD or PACE product line are not eligible to enroll in the Health Home Program.**
31	ELIGIBLE CAPITATION GUARANTEE	Coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for Medicaid Services. No coverage for medical services/supplies.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.

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CODE	ELIGIBILITY BENEFIT	ELIGIBILITY BENEFIT DESCRIPTION	COMPATIBLE WITH HEALTH HOME SERVICES	POLICY NOTES
32	ELIGIBLE PCP OR ELIGIBLE PCP WITH PHARMACY CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH AND PHARMACY CARVE OUT OR ELIGIBLE PCP WITH FAMILY PLANNING CARVE OUT (ONLY) OR ELIGIBLE PCP WITH MENTAL HEALTH AND FAMILY PLANNING CARVE OUT OR ELIGIBLE PCP WITH MENTAL HEALTH, FAMILY PLANNING, AND PHARMACY CARVE OUT OR ELIGIBLE PCP WITH FAMILY PLANNING AND PHARMACY CARVE OUT	Safety Net recipient covered under a Prepaid Capitation Program (PCP). The client is PCP eligible as well as eligible for limited fee-for-service benefits.	**YES (See notes)**	Care managers should work with members Managed Care Plan to obtain necessary services. **Members in a FIDA, FIDA-IDD or PACE product line are not eligible to enroll in the Health Home Program.**
33	ELIGIBLE CAPITATION GUARANTEE	Safety Net recipient coverage for Managed Care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for Medicaid services. No coverage for out of plan medical services/supplies.	**NO (See notes)**	Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine whether recipient is eligible for additional coverage and therefore can be enrolled in a Health Home.
34	FAMILY HEALTH PLUS	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.	**YES (See notes)**	Due to the expansion of Medicaid eligibility requirements, individuals previously eligible for FHP may be eligible for Medicaid. Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine eligibility. UPDATE: Code disabled 1/1/15
36	FAMILY HEALTH PLUS	Coverage for FHP premiums only. The FHP plan provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for FHP services. No coverage for out of plan medical services/supplies.	**NO (See notes)**	Due to the expansion of Medicaid eligibility requirements, individuals previously eligible for FHP may be eligible for Medicaid. Care managers can work with State Health Insurance Exchange/HRA/LDSS to determine eligibility. UPDATE: Code disabled 1/1/15

Updated: 1/6/2020