



NEW YORK STATE Medical Indemnity Fund

Enrollee Handbook

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ENGLISH

This is important information regarding your enrollment in the Medical Indemnity Fund. Please have it translated.

HAITIAN CREOLE

Sa se yon enfòmasyon enpòtan konsènan re-awòlman ou nan Fon Endamnite Medikal, Medical Indemnity Fund. Fè tradwi li souple.

KOREAN

이것은 의료 보장 기금 등록에 관한 중요 정보입니다. 번역해 주십시오.

RUSSIAN

Здесь содержится важная информация, касающаяся вашей регистрации в фонде "Medical Indemnity Fund." Пожалуйста, переведите документ.

CHINESE

本信息为注册纽约州医疗赔偿基金会的重要信息。请翻译。

SPANISH

Esta es información importante con respecto a su inscripción en el Fondo de Indemnización Médica, Medical Indemnity Fund. Por favor téngalo traducido.

1.0 About The Medical Indemnity Fund

The Medical Indemnity Fund (MIF) was established in 2011 to provide a funding source for future health care costs associated with birth-related neurological injuries. Enrollees of the Fund are plaintiffs in medical malpractice actions who have received either court-approved settlements or judgments deeming the plaintiffs' neurological impairments to be birth-related. Enrollment in the Fund is for the enrollee's lifetime. MIF covers qualifying health care costs, which includes but is not limited to the future medical costs for hospital, surgical, nursing, dental, rehabilitation services pursuant to New York Public Health Law Article 29-D.

Public Consulting Group LLC. (PCG), has been designated as Fund Administrator by the New York State Department of Health to administer the MIF in accordance with New York Codes, Rules and Regulations, Title 10 (10 NYCRR) subpart 69-10. As MIF's Administrator, PCG oversees the MIF enrollment process, provides technical and case management support to enrollees and families, and adjudicates requests for services requiring prior authorization. PCG is also the MIF Claims Administrator responsible for health care and pharmacy benefit claims processing.

2.0 WELCOME TO THE MIF

PCG would like to take the opportunity to welcome you to the New York State Medical Indemnity Fund. The Case Management and Claims Administration teams are looking forward to working with you to meet your health care needs.

This handbook will provide you with the following information:

- What health care costs are covered by the Fund?
- What case management services are provided?
- Which services require prior approval before they can be provided?
- How are claims submitted?
- What are the pharmacy benefits?
- At the end of the handbook, you will find the Pharmacy Delivery Registration Form.

Please read each of the sections carefully because they will help you to better understand the MIF regulations and definitions regarding qualifying health related costs.

3.0 CASE MANAGEMENT

Case Management is a collaborative process that includes assessment of needs, service planning, coordination, facilitation, and advocacy to identify options and services to meet an individual's health needs. The case manager communicates available resources to ensure quality and cost-effectiveness.

Individualized case management assists with access to care and maintaining medically necessary services. Case management activities may include negotiation and advocacy for services, consultation with providers, navigation through the health care system, psycho-social support, and general education regarding the MIF and health care system.

Goal of Case Management

Case managers share the goal to promote and support your access to health care services. Given the individualized nature of each enrollee, your consent and active decision-making with PCG is essential. PCG supports your right to privacy, confidentiality, self-determination, dignity, and respect as well as nondiscrimination, and compassionate care. PCG strives to ensure that you will be working with a culturally competent Case Manager and quality providers.

What you can expect from your Case Manager:

- Assisting with prior authorizations by helping you complete prior authorization forms and contacting providers for necessary documentation.
- Performing scheduled telephone and/or email contact to ensure all services are meeting Enrollee's needs.
- Assisting with care access by identifying service providers and determining any gaps in care.
- Completing assessment and reassessments of Enrollee's medical condition during a home visit or telephone appointment, at a minimum of annually.
- Developing a comprehensive care plan for all qualifying health care services Enrollee may need.
- Assisting in obtaining service referrals through agency and qualified individuals.
- Coordinating care with all agencies involved in care and wellbeing, including but not limited to Waiver programs, community resources and school-based services.
- Assisting with questions about coverage or operations in the MIF.
- Maintaining continuity of care without interruption of services.
- Guiding you through the MIF process of care coordination and service payment.

4.0 QUALIFYING HEALTH CARE COSTS

The Fund will pay qualifying health care costs as determined by a physician, physician assistant or nurse practitioner, and as defined by the Commissioner of Health in regulation. Examples of qualifying health care costs consist of:

- Medical treatment
- Hospital-based care
- Surgical care
- Nursing care
- Dental care
- Rehabilitative care
- Custodial care
- Durable medical equipment
- Certain environmental modifications
- Assistive technology
- Certain vehicle modifications
- Prescription and non-prescription medications

- Other health care costs for services rendered to, and supplies utilized by Enrollees.

5.0 SERVICES REQUIRING PRIOR APPROVAL

Some services will require your Case Manager's approval before they can be provided and covered by the MIF. See below those services requiring prior approval and how to obtain prior approval.

Services *Always* Requiring Prior Approval

The following services will always require prior approval in accordance with MIF regulations:

- Environmental modifications (EMOD)
- Vehicle modifications (VMOD)
- Assistive technology
- Private duty nursing
- Certain types of transportation for medical care and services (including travel involving overnight accommodations)
- Treatment with a specialty drug
- Experimental treatment
- Myo-electric limbs
- Custom-made durable medical equipment
- Hearing Aids
- Over the counter medications and supplements

Services Requiring Prior Approval When *Certain Limits* Are Exceeded

The following services will require prior approval when defined limits are exceeded:

- More than 1,080 hours of respite care in a calendar year.
- More than 16 hours a day for home health aide services.

Non-Typical Services Requiring Prior Approval

Certain services that are non-typical medical services also require prior approval. Non-typical services may be supplies, equipment, or therapy that may be determined medically necessary. Some common examples include but are not limited to:

- Hippotherapy
- Aqua therapy
- Equestrian therapy
- Formula
- Miscellaneous codes
- Incontinence products
- Massage therapy

Items Not Covered by the MIF

Please note: every day personal hygiene items, such as toothpaste, toothbrushes, deodorant, and other daily necessities are not reimbursable.

How to Obtain Prior Approval

You may start the Prior Approval process by submitting a **PRIOR APPROVAL REQUEST FORM**. In this form you will need to provide the following information:

- MIF Enrollee ID: NYS _____
- Name of Person(s) Submitting Request
- Signature of Person(s) Submitting Request
- Relationship to Enrollee
- Date Request Submitted
- Item and/or Services Requested: (services you are requesting)
- Provider(s) Supplying the item and/or Services Requested
- Reason for the Request

PRIOR APPROVAL REQUEST FORM can be found on the MIF website at: www.health.ny.gov/mif. Once completed and signed, you can submit it by:

- Mail: MIF c/o PCG, PO Box 784 Greenland, NH 03840-0784
- Fax: 518-344-1293
- Scan it and email to your Case Manager

Minimum Required Documentation for Prior Approval or Authorization Processing

For services requiring prior approval or authorization, you will be required to submit, at a minimum, the following information with your Prior Approval Request Form:

- A Letter of Medical Necessity: a physician signed letter specifically identifying the service or product needed and the medical reasons for the item(s).
- Your Case Manager may ask for additional information.

Processing of Prior Approvals

We review all authorization requests. After a determination is made, we will send you a letter informing you of our decision, within 30 days from receiving all required documents.

If a service requiring prior approval is approved, your Case Manager will provide you with an approval letter that includes an authorization number, as well as any limitations or expiration date, if applicable. You will need to obtain a new prior approval for services beyond the approval dates.

If a service requiring prior approval is denied, you may request a review by completing a **REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM** within 30 days of the notice of denial. You can find the form on the MIF website at www.health.ny.gov/mif.

Certain services, such as vehicle and environmental modifications have additional requirements. Please see the prior approval process below for specific categories:

5.1 ENVIRONMENTAL MODIFICATIONS, VEHICLE MODIFICATIONS AND ASSISTIVE TECHNOLOGY

Per MIF regulations, **environmental modification** means interior or exterior physical adaptation to the residence in which an Enrollee lives that is necessary to ensure the health, welfare, and safety of the Enrollee, enables them to function with greater independence in the community and/or helps avoid institutionalization, and has been ordered by a physician.

Environmental modifications include but are not limited to:

- Ramps
- Widened doorways
- Handrails
- Accessible bathroom modifications, such as grab bars.
- Roll-in showers
- Vertical lifts, elevators only when there is no other safe and cost-effective alternative.
- Cabinet and shelving adaptations.

Environmental modifications do not include:

- Any routine home maintenance.
- Adaptations or modifications that are of general utility.
- Modifications that do not provide direct medical or remedial benefit to the Enrollee.
- With respect to new construction, EMODs do not include modifications needed as a result of avoidable barriers created by the new construction floor plan.

With respect to new construction, environmental modifications do not include modifications needed as a result of avoidable barriers created by the new construction floor plan. Rent and/or utility expenses incurred while the adaptation is taking place are not covered by the MIF.

Guide to Environmental Modification (EMOD) for Enrollees and Their Families

Pre-Modification Phase:

It is helpful to discuss the Enrollee's needs with your Case Manager.

PRIOR APPROVAL REQUEST FORM

- Must have a letter from the Enrollee's physician on letterhead that explains how each requested modification is medically necessary, such as how it would address the Enrollee's safety, health care needs, or barrier to function.
- Proof of Ownership (deed/title)
- Proof of Homeowners Insurance
- Rented residence – must have Notarized Letter from the Landlord giving permission to the modification, proof of ownership, both renter's insurance and homeowner's insurance.
- Home is purchased by Trust – must have letter verifying that the Trustee is in agreement with the modification request.
- If non-custodial parent is applying for a modification – must provide a certified copy of the court order awarding shared physical custody.

Evaluator Assignment:

- After the necessary documents are complete and received, an EMOD Evaluator will be assigned to you.
- EMOD Evaluator will review the requests on the Prior Authorization Request Form and the physician's Letter of Medical Necessity and will call you to schedule a home visit.
- EMOD Evaluator will come to the home to evaluate the requests and then submit a written evaluation report to the MIF for review. The evaluation will contain the recommended EMODs to meet the Enrollee's needs.
- If you have any changes to the original request, you must bring it to the attention of the Enrollee's Case Manager for review.

MIF Review of the Comprehensive EMOD Evaluation:

- All information submitted will be reviewed.
- If any information is missing, the Case Manager will work to obtain the additional information. This can delay the process.
- A determination will be made based on all information submitted.
- A letter is sent to you with instructions for the next steps.

If Approved or Partially Approved, you move on to the Bidding Process:

- You will need to find general contractors to submit bids on the approved projects. If you are unable to locate general contractors within your area, please contact the Case Manager for assistance in contacting qualified contractors.
- You should give a copy of the EMOD Determination Letter and the Bidding Instruction Letter to the General Contractors before they start their review and home assessment.

*****Only approved items in the Determination Letter are to be included in the BID *****

- If 3 bid sources cannot be located within a reasonable distance of the home, you will need to submit a letter attesting that you have attempted to secure 3 bids without success.
- Once you obtain all bids, you will send these to the Case Manager. These bids will be reviewed by the EMOD Evaluator and the MIF. After review, a General Contractor will be chosen, and you will receive a letter for your consent for the work to begin with the successful contractor.
- You must review, sign, and send the Consent Letter back to the Case Manager.
- Once the signed letter is received, the initial one-third payment can be authorized to the General Contractor, which may take up to 45 days. The contractor can then begin work.

Construction:

- You will discuss EMOD progress with the Case Manager at least once a month. **Report any issues or changes immediately to the Case Manager.**
- Any communication you have with the EMOD Evaluator needs to be shared with the Case Manager immediately.
- Upon completion of the construction, contact the Case Manager to proceed with the next steps.

Completion of EMOD:

- EMOD Evaluator will schedule a post-modification evaluation visit with the Enrollee/family.

- Post-modification report will be drafted by the Evaluator.
- You, the General Contractor, and the EMOD Evaluator must sign off confirming the project is complete according to the specifications in the EMOD determination letter and document that all modifications were tested for functionality.
- Evaluator then submits the written post-modification evaluation report to the Case Manager.
- If the post-modification evaluation is inconsistent with the approved requests, outreach will be made to the Evaluator/Enrollee/family to determine why it is inconsistent, since this can affect payment of the final invoice.
- The final report and invoice are reviewed and once they are accepted, the final payment can be authorized to General Contractor, which may take up to 45 days.

Vehicle Modifications (VMODs)

Per MIF regulations, **vehicle modification** means:

- Adaptive equipment designed to enable an Enrollee to operate a vehicle or be transported in a vehicle such as hand controls, deep dish steering wheels, spinner knobs, wheelchair lock down devices, parking brake extensions, foot controls, wheelchair lifts, left foot gas pedals; or
- Changes to the structure, internal design, or existing equipment of a vehicle, such as replacement of the roof with an elevated fiberglass top, floor cut-outs, extension of the steering column, raised door, repositioning of seats, wheelchair floor, and dashboard adaptations.

Please note that you need to own the vehicle before any modifications can be approved.

As per MIF regulations, **assistive technology** means those devices, controls, appliances, items, pieces of equipment, or supplies of either a communication or an adaptive type, determined necessary by a physician for purposes of the Enrollee’s habilitation, ability to function or safety in his or her current or desired residence which are not listed in the Medicaid Durable Medical Equipment (DME) Provider Manual at:

<https://www.emedny.org/ProviderManuals/DME/index.aspx>

The Prior Approval process for **environmental modification**, **vehicle modification** or **assistive technology** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter of Medical Necessity from your physician, and:

For environmental modification:	For vehicle modification:	For assistive technology:
Proof of ownership of the residence, such as deed and/or taxes and homeowner insurance.	Proof of ownership of the vehicle, such as registration and vehicle insurance.	Copies of all assessments made to determine the necessary assistive technology, including an assessment of

Evaluation by rehabilitative evaluation agency, rehabilitative specialist, or an independent building contractor.	Vehicle Modifications and Equipment Evaluation obtained from a Driver Rehabilitation Specialist.	the Enrollee's unique functional needs and the intended purpose and expected use of the requested assessment technology.
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Your Case Manager will determine if the documentation is complete and will notify you if anything is missing. The MIF will evaluate the request for appropriateness, and if approved, you will need to obtain three bids for the requested work.

Each bid must include:

- A description of work and specifications of the work, and:

For environmental modification:	For vehicle modification:	For assistive technology:
Proof of insurance for the contractor for the duration of the project.	Proof of ownership of the vehicle. Vehicle title, bill of sale from a dealership, proof of registration and insurance for vehicle are required.	If assistive technology equipment is less than \$2,500, documentation showing the prices from three different suppliers may be submitted. In other cases, formal bids from suppliers must be submitted.
Statement signed by the contractor that the work will be done in a workmanlike manner, using materials suitable for the project construction while maintaining the safety of the enrollee and household members. The contractor agrees to comply with all applicable building and zoning laws.	Statement signed by the contractor that the work will be done in a workmanlike manner, using materials suitable for purposes of the project.	

If you are unable to obtain three bids, you will need to provide a written explanation of why three bids were not obtained. You will also need to explain why the one or two bids submitted can be considered as reasonably priced.

Next, your Case Manager and the Evaluator will review the bids. Factors determining the best bid are based on price and quality including durability, warranties provided, product safety and workmanship offered.

Your Case Manager will discuss the bids with you and the reasons for selecting a particular bid. If the price difference between the two lowest bids is less than 10%, you can choose a bid based on your preference. If you disagree with the determination, you can request a review of the decision.

Your Case Manager will notify the successful bidder and authorize one-third payment of the total job amount. After the work is completed, an evaluator performs a post-modification assessment. This evaluation ensures that the modification meets your needs, is consistent with the initial evaluation, and follows all safety standards. After the post-modification evaluation is completed and approved, final payment is authorized.

Steps are shown in Figure 1 on the following page:

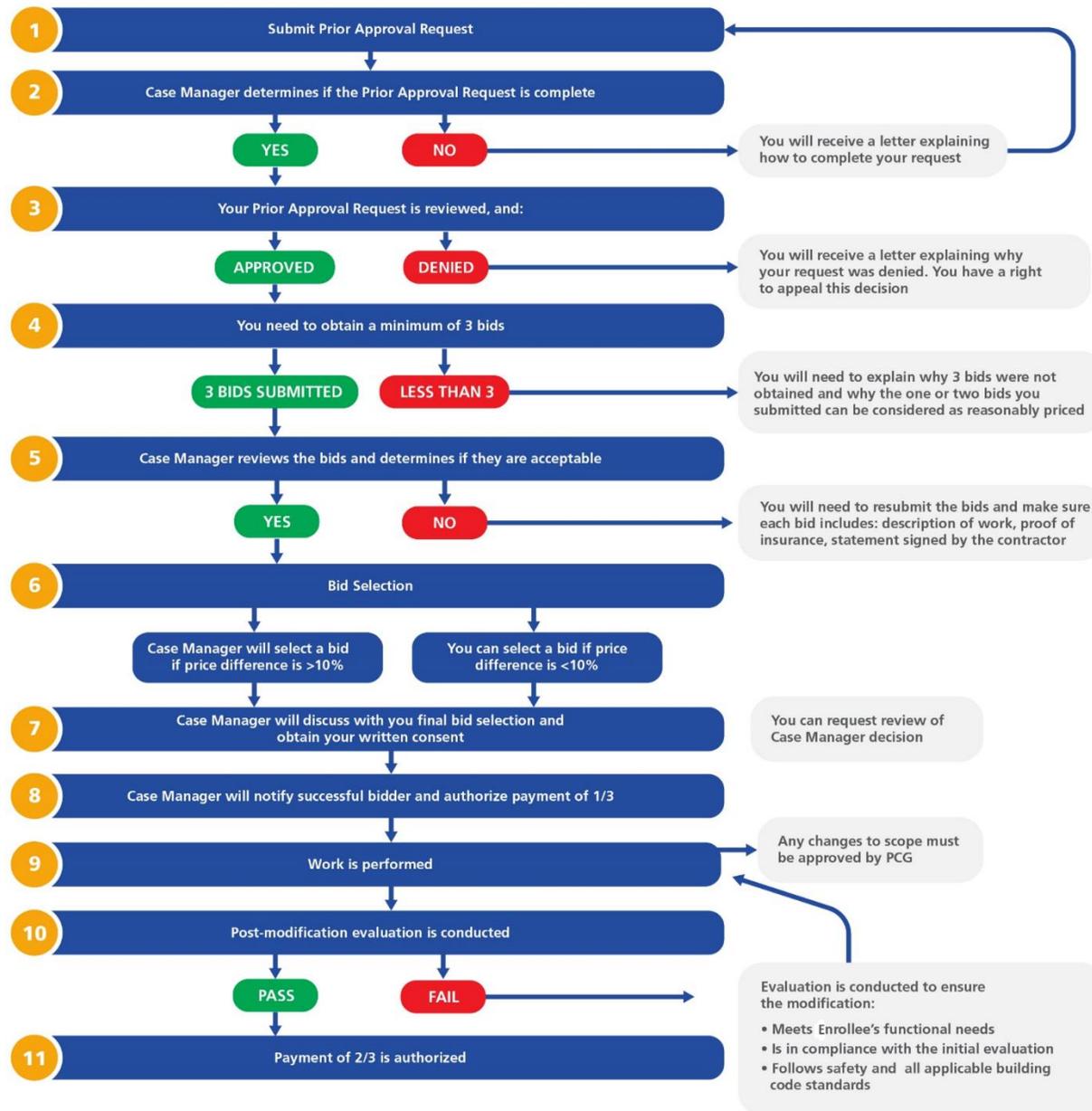


Figure 1. Prior Approval Process for Environmental Modification, Vehicle Modification and Assistive Technology

5.2 Private Duty Nursing

The Prior Approval process for **private duty nursing** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter of Medical Necessity
- If the service will be provided at **home**, submit physician’s written order and treatment plan.
- If the service will be provided in **hospital**, physician’s order must state that the Enrollee needs individual and continuous care beyond that available by the hospital staff.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness, and you will be notified of the decision by mail.



Figure 2. Prior Approval Process for Private Duty Nursing, Transportation, Experimental Treatment, Specialty Drug, and Home Supplies

If your private duty nursing request is denied, you can request a review by submitting a **REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM** within 30 days of the notice of denial. The form is

located on the MIF website.

5.3 TRANSPORTATION

Prior authorization is required for all non-emergency transportation related to health care appointments (the one exception is for Enrollee self-transportation). Travel related expenses, including hotel and airfare, also require prior authorization. For medical appointments over 50 miles meal reimbursement is available.

Self-transportation – which includes taxis, car services (such as Uber/Lyft), and public transportation – does not require prior authorization but requires proof of visit when submitting for reimbursement.

The Prior Approval process for **transportation** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**

- A request for prior approval for non-emergency ambulance transportation or transportation by ambulette must be accompanied by the order of the Enrollee's attending physician, nurse practitioner, or physician assistant.

Transportation requests may be made for a one-time appointment or for multiple appointments during a specific time.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness, and you will be notified of the decision by mail.

We will use the following criteria to determine whether to approve a transportation request:

- What is the nature and/or severity of Enrollee's condition?
- Is there a need of multiple treatments or visits over a short period of time?
- What is the distance between the Enrollee and the provider?
- What is the cost of travel?
- Is there a medical necessity for a specific provider that requires additional travel?
- Are there any other unique circumstances?

If your transportation request is denied, you can request a review by submitting a [REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM](#) within 30 days from receipt of the denial. The form is located on the MIF website.

5.4 EXPERIMENTAL TREATMENT

As per MIF regulation, **experimental treatment** means a drug, device, or treatment for which:

- There is insufficient outcome data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required from the FDA for marketing to the public has not been granted; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of an investigational new drug treatment pursuant to 21 C.F.R. § 312.21 or is the subject of an investigational device treatment pursuant to 21 C.F.R § 812.36; or
- The written protocol or protocols used by the treating facility or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental or investigational.

The Prior Approval process for **experimental treatment** starts when you submit:

- [PRIOR APPROVAL REQUEST FORM](#)
- Letter from the treating physician explaining why the Enrollee needs the experimental treatment.
- Documentation indicating that standard treatment has not been effective for the Enrollee or there is no standard treatment available to treat the enrollee's condition, injury, or impairment.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness, and you will be notified of the decision by mail.

If your experimental treatment request is denied, you can request a review by submitting a [REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM](#) within 30 days from receipt of the denial. The form is located on the MIF website.

5.5 SPECIALTY DRUG

As per MIF regulation, **specialty drug** means a drug that is typically high in cost and has one or more of the following characteristics:

- It is a component of complex therapy for treatment of a complex disease.
- Requires specialized patient training and coordination of care prior to therapy initiation and/or during therapy.
- Requires unique patient adherence to treatment regimen and safety monitoring of the patient during treatment with the drug.
- Requires unique handling, shipping, and storage; and
- Presents a potential for significant waste because of the way the drug is packaged/dispensed or the failure to follow accepted clinical protocols prior to administration to the patient or both.

The Prior Approval process for **specialty drug** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Written statement from your physician stating why treatment with the specialty drug is necessary, what other alternatives have been tried or explored, and what testing the Enrollee has undergone for purposes of determining whether treatment with the specialty drug is appropriate and safe for the Enrollee.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate the complete request for appropriateness, and you will be notified of the decision within three business days of receipt of all necessary information.

If your specialty drug request is denied, you can request a review by submitting a **REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM** within 30 days from receipt of the denial. The form is located on the MIF website.

5.6 HEALTH-RELATED HOME CARE SUPPLIES

Covered home care supplies may include but are not limited to the following: nutritional supplements and feeding supplies, chux/under-pads, ointments, and disposable gloves. The cost of diapers is covered by the MIF for Enrollees whose developmental delays, because of a neurological birth injury requires the continued use of diapers beyond the expected age of toilet training.

The Prior Approval process for **home care supplies** starts when you submit:

- **PRIOR APPROVAL REQUEST FORM**
- Letter of Medical Necessity from your physician.

Your Case Manager will determine if the documentation is complete and will contact you if something is missing. The MIF will evaluate a complete request for appropriateness, and you will be notified of the decision by mail. If your request is approved, your Case Manager will assist you in obtaining items from homecare supply vendors who accept the MIF for payment and who can deliver these supplies to your home address. We will assist you so that routine ordering and delivery of supplies can be set up in a manner that best meet your needs.

Please keep your Case Manager informed of any changes in your routine home care supply needs once this process is in place with a vendor. This will allow the Case Manager to update the authorization and get all the necessary documentation for the services.

This process is in place so you can avoid out of pocket payments for this type of expense. Work with your Case Manager to locate a vendor so you can benefit as soon as possible.

If you need to purchase homecare supplies and must pay out of pocket while we are working with you to set up routine supply delivery or, if we have determined that there is no vendor available to service your geographical area, please submit your itemized receipt(s) and fill in a **GENERAL REIMBURSEMENT FORM**.

If your home care supplies request is denied, you can request a review by submitting a **REQUEST FOR REVIEW OF DENIAL PRIOR APPROVAL FORM** within 30 days from receipt of the denial. The form is located on the MIF website.

6.0 CLAIM SUBMISSION GUIDANCE

We encourage providers to submit claims for reimbursement directly to the MIF. Providers should use industry standard CMS-1500 and UB-04 claim forms. Please encourage your providers to call us if they have any questions about submitting claims or the MIF. Make sure you show your provider your MIF ID card so that they can bill the Fund directly.

In case you are submitting the claim, the MIF support team will help you to submit complete and accurate claims with supporting documentation. Please do not hesitate to contact us with any questions regarding the claim submission process.

To submit a claim, please complete the **GENERAL REIMBURSEMENT FORM** or **TRAVEL REIMBURSEMENT FORM**. In addition to the standard form, additional information is needed from you for certain claims to avoid unnecessary delays in reimbursement.

You can submit your claims by:

- Mail: MIF c/o PCG, PO Box 784, Greenland, NH 03840-0784
- Email: NY_DOH_MIF@pcgus.com

Please note:

- We do not accept or process photographs or faxes of claims.
- The MIF must receive completed claims within 90 days from the date services are rendered or purchased.

Below you will find additional information that we need to process specific types of claims:

- **Respite Care**

Respite workers are encouraged to bill the MIF directly and can find the directions for claims submission under the provider section on the MIF website. The following requirements apply to all respite claims submitted by you:

- **GENERAL REIMBURSEMENT FORM**
- Requires prior authorization if more than 1,080 hours of respite care are provided in a calendar year.
- Specific list of services provided during respite.
- Dates of respite care.
- Number of respite hours provided per day.
- Name of respite worker.

- Hourly rate charged and total billed amount.
- Copies of receipts for the hours worked.
- **Supplies**
 - **GENERAL REIMBURSEMENT FORM**
 - List of specific supplies requested.
 - Copies of receipts for the items requested to include descriptions, amount paid for each item and the date paid.
- **Non-Emergency Transportation and Travel Related Expenses (hotel, meals, airfare)**
 - **TRAVEL REIMBURSEMENT FORM**
 - All transportation (except for enrollee self-transportation) and travel related expenses (including hotel and airfare) require prior authorization.
 - Meal reimbursement is provided for medical appointments over 50 miles from the home.
 - List of specific expenses requested for reimbursement.
 - Evidence of medical appointment associated with travel.
 - Copies of receipts for the items requested.
- **Self-transportation** including taxis, car services such as Uber/Lyft, and public transportation
 - **TRAVEL REIMBURSEMENT FORM**
 - Meal reimbursement is provided for medical appointments over 50 miles from the home.
 - List of specific expenses requested for reimbursement.
 - Evidence of medical appointment associated with travel.
 - Copies of receipts for the items requested: receipts for mileage, parking, tolls, public transit receipts, Uber/Lyft receipts.
- **Mileage, Tolls, Parking**
 - **TRAVEL REIMBURSEMENT FORM**
 - Copies of receipts for expenses.
 - Evidence of medical appointment associated with mileage, tolls, and parking.
 - Starting point address, destination address, ending address (mileage will be determined using MapQuest).
- **Office Visit Copays, Coinsurance and Deductibles**
 - **GENERAL REIMBURSEMENT FORM**
 - Copay receipts need to be on office or pharmacy letterhead and must include date of service, provider name, patient name, amount paid, indication that amount is a copayment.
 - Coinsurance and Deductibles from primary insurance carrier:
 - Enrollees should either give their MIF information to providers at the time of their visit and request they bill the MIF directly or obtain an itemized bill from the provider and submit to the MIF with a copy of primary insurance Explanation of Benefits (EOB) if applicable.
 - Balance Due or Credit Card Statements:
 - Balance due or credit card statements cannot be processed for reimbursement due to lack of information required to determine accurate reimbursement. Enrollees have two options: 1) They may supply their MIF information to providers and request they bill the MIF directly or,

- 2) They may obtain an itemized bill from the provider and submit to the MIF with a copy of primary insurance EOB if applicable.

Coordination of Benefits

Some Enrollees may have commercial health insurance coverage from their parent's employer. If this is your situation, please inform us so that we can update your information and coordinate with the insurer. Coordination of additional coverage with the MIF may lower your medical and out of pocket expenses.

If you have commercial health insurance, it will always be primary (or first payer) before the MIF. All claims must be submitted to the commercial health insurance before submitting the claim to MIF. If the primary insurance does not pay for the entire claim, the provider should submit the itemized bill to MIF with a copy of the EOB they received from the primary insurance. The MIF requires an EOB before any payment can be made. If the MIF receives a claim without the primary EOB, the claim will be denied until the EOB is received and the claim can be adjusted.

If the primary health insurance does not cover certain services that are covered under the MIF, please submit a document from the primary payer that lists what is not covered. This can be in the form of a letter from the commercial health insurance or a copy of the "What is Not Covered" or "Exclusions" section of your commercial health insurance plan booklet. We can use this document for processing these claims. We know that having more than one coverage can be confusing. Please call us if you have any questions.

If your primary health insurance is Medicaid, you must inform your local county social services so that the MIF shows as a third-party payer on your eligibility file. Please do this within thirty days of enrollment into the MIF. You should also let your Case Manager know if you are enrolled in Medicaid and if you are receiving any services or waiver services through Medicaid, so we can coordinate your health care services.

Payments

Under the New York State Regulations, the MIF reimbursements are based on 80% of the usual and customary rates (UCR). This means that 80% of the providers in the geographic area of where services were rendered are charging what the Fund is paying. The data to determine these rates is gathered from all payers and is calculated by FAIR Health.

If there is no usual and customary amount for the services being provided, the MIF reimburses 130% of New York Medicaid, or Medicare rate, whichever is higher.

All rates are subject to periodic adjustments due to updated data, inflation, and budgetary considerations.

Because the MIF is not an insurance company, there is no provider network

The MIF has not contracted with any providers to render services at guaranteed rates because it is not an insurance company. While you are free to see any provider you wish, we strongly encourage you ask your provider if they accept MIF payments. Providers cannot bill the Enrollee or persons authorized to act on behalf of the Enrollee for any additional amount beyond the amount covered by the Fund.

Providers are encouraged to accept payments directly from the Fund.

If a provider wants to know what the MIF will pay for a service prior to rendering the service, they should send a request to the MIF with the following information:

- Provider Name and National Provider Identifier (NPI)
- Procedure Code(s) and Billed Amounts for each code
- Approximate date services are expected to be rendered

The MIF will respond within 2 business days from inquiry with the payment the provider can expect to receive.

When you receive billing statements

Most providers have billing cycle procedures. For example, they may send a statement every 30 days until payment is received. Some providers may send you the statements as part of their billing practice. Often, these statements are sent to you for your information only, but occasionally they are requesting that you pay a balance after they received payment from your commercial health insurance or the MIF. Please be advised, the MIF processes claims within **45 days** once all documents required and/or requested are received. While the claim payment may seem “late”, it may just be in process. Before making any payments, please call us. We will do our best to help you understand if any action on your part is necessary.

7.0 PHARMACY BENEFITS AND PRESCRIPTION PROGRAM

MIF covers the cost of all approved medications that the Enrollee’s health care provider has determined medically necessary.



Citizens Rx is the MIF’s pharmacy benefit partner. Covered medications can be filled at no out-of-pocket cost to you at one of the many participating pharmacies, including CVS, Rite Aid, Walgreens, and Wal-Mart. You can also visit citizensrx.com or call Citizens Rx customer service at 1-855-NYMIF33 (1-855-696-4333) to find a pharmacy near you.

Citizens Rx can also provide long-term medications by mail, through the mail order service, PraxisRx. The pharmacy mail program makes it easy and convenient for you to get long-term medications delivered directly to you. Enclosed in this handbook are instructions along with a mail order claim form to complete.

Although most medications are covered under the MIF pharmacy benefit, there may be some medications that require prior authorization by the MIF before they will be covered. To avoid any delays in filling any new medications, please have your health care provider call Citizen’s Rx at the number above Citizen’s Rx will be able to tell your health care provider if prior authorization is required.

Five ways to start using your Citizens Rx prescription program:

- Bring your prescription to a Citizens Rx participating pharmacy.
- Fill out and mail the service form – use the one included in this handbook or print one at citizensrx.com.
- If you currently have a prescription for a controlled substance or compound medication, you will need an updated prescription in order to fill via the mail service.
- Visit citizensrx.com.
- Call Citizens Rx at 1-855-NYMIF33 (1-855-696-4333).

8.0 CONTACT INFORMATION

The New York State Medical Indemnity Fund and Public Consulting Group LLC are dedicated to excellence in service as we partner with you in meeting each Enrollee's health related needs.

If you have MIF-related questions, please do not hesitate to contact your Case Manager directly or the Fund Customer Service Department via a toll-free line at 1-855-NYMIF33 (1-855-696-4333) from Monday through Friday during normal business hours, 8:30 am to 5:00 pm Eastern Standard Time or via email at NY_DOH_MIF@pcgus.com

You can also visit the Fund website for updates, forms, and frequently asked questions at: www.health.ny.gov/mif

Once again, welcome to the MIF and we look forward to working with you.

9.0 Information for Providers about the New York State Medical Indemnity Fund

Please take this form to each health-related provider (have them make and keep a copy on file) as it contains important information about the MIF and explains how providers can file claims for services rendered.

What is the Medical Indemnity Fund and Why Was It Created?

The Medical Indemnity Fund (“Fund” or “MIF”) was established in 2011 to provide a funding source for future health care costs associated with birth-related neurological injuries. Enrollees of the Fund are plaintiffs in medical malpractice actions who have received either court-approved settlements or judgments deeming the plaintiffs’ neurological impairments to be birth-related.

The Fund’s purposes are to (1) pay or reimburse the costs necessary to meet the health care needs of qualified plaintiffs throughout the plaintiff’s lifetime and (2) lower the expenses associated with medical malpractice litigation throughout the health care system. To achieve its purposes, it is designed to pay the cost of all future health care needs of plaintiffs who have received either a court-approved settlement or a judgment resulting from a medical malpractice action alleging that the plaintiff’s neurological injuries were the result of medical malpractice during the delivery admission.

The Fund was created as an amendment to Article 29-D of the New York Public Health Law in 2011. Regulations governing the proper administration of the Fund are the responsibility of the Commissioner of Health in consultation with New York State Department of Financial Services. The regulations are set forth in 10 NYCRR Subpart 69-10.

Information about the Fund can be found on the DOH website at: www.health.ny.gov/mif

Who Is Eligible for Enrollment in the Fund?

Any person who has been deemed in a court-approved settlement or found in a judgment to have sustained a “birth-related neurological injury” as a result of medical malpractice or alleged medical malpractice is a “qualified plaintiff” for enrollment purposes.

What Costs Will the Fund Cover or Reimburse?

The Fund will pay or reimburse the cost of those health care services, supplies, equipment, and medications that the qualified plaintiff’s physician, physician assistant or nurse practitioner has determined are necessary to meet the qualified plaintiff’s health care needs. Such costs include those incurred for:

- Medical treatment
- Nursing care
- Prescription & non-prescription medication
- Assistive technology
- Other health care costs related to services, supplies, equipment, and medication utilized by Fund Enrollees.
- Hospital-based care, including surgical care
- Dental care
- Durable medical equipment
- Certain environmental & vehicle modifications

Services, supplies, or equipment provided to or available to enrollees under an individual Education Program, Preschool Supportive Health Services, and the Early Intervention Program or through any commercial insurance under which the enrollee is covered are not covered by the Fund.

At What Reimbursement Rates Are Qualified Health Care Costs Paid by the Fund?

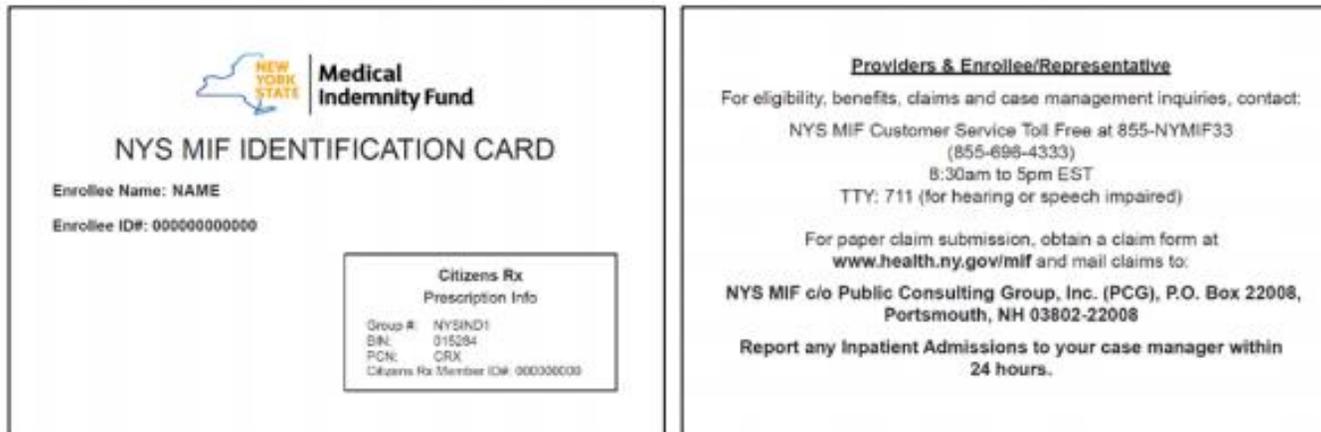
Qualifying health care services are reimbursed at the 80th percentile of the “usual and customary rate” for that type of practice in the geographic area in which the practice is located, as reported by Fair Health, Inc. Where no such rate exists, qualifying health care services are paid at the greater of 130% of Medicaid or the Medicare rate. Providers cannot bill the qualified plaintiff or persons authorized to act on behalf of the plaintiff for any additional amount beyond the amount covered by the Fund.

Who Administers the Fund?

The Fund is administered by DOH. DOH has contracted with Public Consulting Group LLC (PCG) to administer health care and pharmacy benefit claims processing and day-to-day operations of the Fund.

MIF Identification Cards

Approved Enrollees are issued NYS MIF Identification Cards (sample below).



Payment Request Submission Instruction

The New York Medical Indemnity Fund accepts both electronic and paper claims with industry standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act (HIPAA) Transaction Set Standards. Providers seeking payment or reimbursement of qualifying health care costs may send completed CMS 1500 or UB 04 Forms to:

New York State Medical Indemnity Fund
c/o PCG
PO Box 784
Greenland, NH 03840-0784

The Fund offers two options for submitting Electronic Data Interchange (EDI) claims. With the appropriate option in place for your electronic workflow, electronic billing results in fewer errors, lower costs, and increased efficiency for businesses on both ends of the transaction. These options are detailed below:

- Clearinghouse Submitters**
 Standard 837 file submission through a clearinghouse using the Fund's receiver ID, NYDFS. This PIN is the identifier at the Clearinghouse to route claims directly to the Claims Operation Department.

- **Direct Submitters**

This option is for providers who choose to create their own 837 file and submit that file directly to the MIF portal. If you wish to request online access, you can send a request via email with your Tax ID and group NPI to NY_DOH_MIF@pcgus.com

Claims must be submitted within 90 days of the date of service unless the provider obtains permission from the Fund to file a claim later than that date upon a showing of good cause for the delay. Providers must submit a W9 with their initial claim to avoid payment delay.

Feel Free to Call (Toll Free): 1-855-696-4333 (NYMIF33)
with any questions you may have

PCG complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Health Information Technology for Economic and Clinical Health Act (HITECH) Breach Notification Rule, and all federal requirements related to 42 CFR 495, Standards for the Electronic Health Record Technology Incentive Program, Subpart D, such as, but not limited to 42 CFR 495.324, 495.346, 495.354 and 495.360 as well as Social Security Administration (SSA) Required Provisions for Data Security.

PCG uses data encryption to move data between entities over external networks that are outside of the PCG firewall. PCG strictly adheres to HIPAA guidelines and encrypts Protected Personal Information (PPI) and Protected Health Information (PHI). This is done for data at rest and in databases. PCG uses secure File Transfer Protocol (FTP) software to both send and receive data. Only authorized personnel are allowed to access client data. Client data is not co-mingled with other client data at any time.

10.0 FORM INFORMATION

The following forms are available on the Fund website. To access these forms, please visit:
https://www.health.ny.gov/regulations/medical_indemnity_fund/forms_inst.htm.

ACKNOWLEDGEMENT FORM

You must sign and return this form as soon as possible in the self-addressed stamped envelope provided with this Handbook.

PRIOR APPROVAL REQUEST FORM

Use this form to request services that require Case Manager's prior approval.

AUTHORIZATION FORM

Use this form to authorize additional persons to obtain and submit information on behalf of the Enrollee.

GENERAL REIMBURSEMENT FORM

Use this form for health-related expenses. Please make sure you have already obtained any necessary authorization before submitting your claim.

TRAVEL REIMBURSEMENT FORM

Use this form for health-related travel. Please make sure you have already obtained any necessary authorization before submitting your claim.

The Pharmacy Delivery Registration Form is included below:

PHARMACY DELIVERY REGISTRATION FORM

Use this form to register for pharmacy home delivery service.

PHARMACY DELIVERY REGISTRATION FORM

THE BENEFITS ARE CLEAR
PraxisRx Pharmacy Home Delivery

PraxisRx Pharmacy Home Delivery is an easy-to-use pharmacy delivery service that works with your pharmacy benefit.

Use our service for medications you take regularly - both for new and refills. You can trust our registered pharmacists and experienced team to fill your prescriptions accurately, promptly, and conveniently.

SAVE TIME

- No trips to the pharmacy
- No waiting in line
- Fast, convenient service
- Order fewer times per year
- Free delivery to your door or PO Box

PraxisRx
AT PraxisRx

ALL HANDS WORK TOGETHER AS ONE



We look forward to serving your

HOME DELIVERY PHARMACY NEEDS

Mail Prescriptions to:

PraxisRx
5455 W. Waters
Suite 214
Tampa, FL. 33634

1 (844) 553-7500
www.praxisrx.com

PraxisRx Pharmacy HOME DELIVERY

A Pharmacy at Your Door



HOW TO USE PRAXISRX PHARMACY HOME DELIVERY

OBTAINING YOUR PRESCRIPTION

- PraxisRx Pharmacy can contact your physician for you
- You can obtain a prescription from your physician and send it to PraxisRx Pharmacy by mail
- Your Physician can send a prescription to PraxisRx Pharmacy by fax or through electronic prescribing to PraxisRx Pharmacy
- Be sure to ask your physician to write the prescription for a 90-day supply with three refills and authorize a one-year supply (when appropriate)
- Auto refills may be available to members. Please contact customer service for more information

PAYMENT IS DUE AT TIME OF ORDER

- Credit Card (you can elect to securely save your credit card information for future online or automated voice refills)
- Check (by mail)
- Money Order

REMEMBER

- Allow up to 10 days from the time you mail your prescription until you receive the medication in your mailbox.
- Faster shipping is available, for an additional cost, by contacting customer service.
- Contact customer service for additional forms, or visit our website at www.praxisrx.com to print as many as you need.

ABOUT GENERICS

Generic medications will be used when available and appropriate. The Food and Drug Administration requires a generic medication to be as safe and effective as its brand counterpart. Generic medications are considerably less expensive than brand name drugs.

IF YOU NEED MEDICATION RIGHT AWAY

Request two prescriptions from your physician, one for an initial 30-day supply that your local pharmacy can fill immediately, and one for a 90-day supply with three refills to fill through PraxisRx.

** By law, prescription fax forms and e-prescriptions are valid only from a prescriber's office.*



ADDITIONAL INFORMATION

- Provide your phone number in case we need to contact you
- Provide your e-mail address to receive shipment notifications and refill reminders
- If you need a new prescription, we will contact your physician
- We will contact you by phone if your order is delayed.

PraxisRx Pharmacy
CUSTOMER SERVICE
**Call toll-free
1 (844) 553-7500**

REGISTRATION OPTIONS

Call us with your registration information

Fill out the enclosed registration form

Register online at www.praxisrx.com

Visit our website www.praxisrx.com to register or manage your prescriptions online.



MEMBER INFORMATION

(844) 553-7500 | WWW.PRAXISRX.COM

CARDHOLDER ID# (REFER TO ID CARD)

Grid for Cardholder ID#

GROUP # (REFER TO ID CARD IF APPLICABLE)

Grid for Group #

LAST NAME OF CARDHOLDER

Grid for Last Name

FIRST NAME OF CARDHOLDER

Grid for First Name

DELIVERY ADDRESS (STREET AND APARTMENT NUMBER)

Grid for Delivery Address

CITY

Grid for City

STATE

Grid for State

ZIP CODE

Grid for Zip Code

EMAIL ADDRESS

Grid for Email Address

DAYTIME PHONE NUMBER

Grid for Daytime Phone Number

DATE OF BIRTH (MM/DD/YYYY)

Grid for Date of Birth

GENDER

Grid for Gender (M/F)

Drug Allergies:

- Drug Allergies: No Known Allergy, Aspirin, Codeine, Erythromycin, Iodine, Other, Penicillin, Sulfa

Health Conditions:

- Health Conditions: Arthritis, Asthma, Depression, Diabetes, Epilepsy, Glaucoma, Heart Condition, High Blood Pressure, Other, High Cholesterol, Thyroid, Ulcer

List any OTC, herbal, or other medications you take regularly:

PAYMENT OPTIONS

Payment is due with each order. Do not send cash. If you use a credit card for payment, PraxisRx will bill your credit card for your portion of the drug cost, any special delivery charges and any outstanding balance due.

Credit Card Type (Our preferred payment method for faster service)

- Credit Card Type: MasterCard, Visa, American Express, Discover, Use credit card on file, Please place credit card on file for future orders

ACCOUNT NUMBER

Grid for Account Number

EXPIRATION DATE

Grid for Expiration Date

SECURITY CODE

Grid for Security Code

Check or money order enclosed. Cardholder Signature: Date:

Notes to Pharmacy:

PLEASE READ AND SIGN TO COMPLETE ORDER

I certify that the information provided on this form is correct and authorize the release of information regarding medical history, treatment and prescription drug history to PraxisRx Pharmacy.

Signature: Date:

To refuse generics check here (☐), AND sign and date. PraxisRx Pharmacy substitutes generics when they are medically equivalent to the brand drug prescribed by the doctor. Please sign and date the statement below if you DO NOT want to receive generic products.

"I understand that I have the right to refuse generic medications. I understand this may result in a high cost to me, that I am responsible for payment, and that the drugs are not returnable. When my doctor prescribes a brand drug, I wish to receive the brand drug only and accept the conditions."

Signature: Date:



www.health.ny.gov/mif