

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: New Statewide Form DOH-4471: "Certification of Treatment of an
Emergency Medical Condition"

Attachment: DOH 4471: "Certification of Treatment of an Emergency Medical
Condition"

EFFECTIVE DATE: July 1, 2010

CONTACT PERSON: Local District Support Unit
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this General Information System (GIS) message is to release the new statewide form DOH-4471, "Certification of Treatment of an Emergency Medical Condition". The new form DOH-4471 replaces upstate form LDSS-3955 and New York City Medical Assistance Program (MAP) form MAP-2151. A copy of the DOH-4471 form is attached to this GIS and is available on line at: <http://health.state.nyenet/revldssforms.htm>.

All local departments of social services (LDSS) must begin using the new DOH-4471 form effective July 1, 2010, and must discard any existing supplies of the previous versions of the LDSS-3955 and MAP-2151. Providers will be advised via the Medicaid Update that previous versions of the LDSS-3955 and the MAP-2151 are no longer acceptable and that submission of either of these forms after June 30, 2010, may result in a delay in payment.

The most significant change to the new form is the "Authorization to Release Medical Information" section. The "Authorization to Release Medical Information" section has been moved to the reverse side (side 2) of the form. The DOH-4471 includes both the English/Spanish translation of the authorization to release medical information. Instructions to the provider on how to complete the new DOH-4471 form have also been added to side 2. The DOH-4471 must be issued as a two-sided rather than a two-page document and must not be modified.

The DOH-4471 certification form must be signed by the applicant/recipient (A/R). If the A/R is unable to sign the certification form, his or her authorized representative may sign on behalf of the A/R. The form is not valid without the required signature of the A/R or his/her authorized representative. Signing the DOH-4471 authorizes the LDSS to request information regarding the emergency medical treatment. It also gives the physician or facility permission to provide such information. The treating physician must complete the DOH-4471 and sign and date the form. The physician must, in all cases, make the decision as to whether or not the medical treatment is for an emergency medical condition. Each DOH-4471 form must be retained in the recipient's case file.

The DOH-4471 form has space to accommodate up to four coverage periods (From-To Date(s) of Treatment/Hospital Stay). Each "From-To" date(s) must be entered in the Welfare Management System (WMS) as a separate coverage period, and each coverage period requires a separate Client Notification System (CNS) notice (upstate). NYC manual notice instructions have been issued under separate cover. For any subsequent treatment/hospital stay or continuing treatment for an emergency medical condition, a new DOH-4471 form must be completed, dated, and signed by the A/R, or the A/R's authorized representative, and by the treating physician

The care that can be covered by Medicaid under the definition of an emergency medical condition is time limited and date specific; authorizations for emergency care must include a specific period of time in the past (i.e. at least one day prior to the date of the initial Medicaid application or one day prior to the Transaction Date for recipients in need of continuing care for the treatment of the emergency medical condition). This is because an emergency medical condition by definition is unexpected with sudden onset that requires immediate medical treatment. Medicaid coverage for the treatment of an emergency medical condition starts on the day treatment for the emergency was initiated and ends when the emergency medical condition is no longer an emergency.

The maximum period of time for which "emergency treatment" (coverage code "07") may be entered from one submission of the DOH-4471 form is 90-days. This can be a combination of retroactive, current and prospective coverage. A new DOH-4471 must be obtained from a physician at least once every 90 days, in order to continue the Medicaid coverage. Future (prospective) coverage may not exceed 60 days.

The social services district must notify the provider of the authorization of coverage, the period(s) of coverage and the individual's Client Identification Number (CIN).

Certification of Treatment of an Emergency Medical Condition

Please see reverse side for instructions on how to complete this form.

Patient's Name _____ Date of Birth ____/____/____ CIN # _____
LAST FIRST M.I. MM DD YY IF AVAILABLE

Address _____ City _____ State _____ ZIP _____
STREET

Diagnosis _____

Treatment _____

Date(s) of Treatment/
Hospital Stay

1. From	____/____/____	To	____/____/____	3. From	____/____/____	To	____/____/____
	<small>MM DD YY</small>		<small>MM DD YY</small>		<small>MM DD YY</small>		<small>MM DD YY</small>
2. From	____/____/____	To	____/____/____	4. From	____/____/____	To	____/____/____
	<small>MM DD YY</small>		<small>MM DD YY</small>		<small>MM DD YY</small>		<small>MM DD YY</small>

Medicaid coverage may be available to the above named individual for care and services (exclusive of care and services related to an organ transplant procedure) that were necessary for the treatment of an "emergency medical condition." Under federal law [42 USC 1396b(v)(3), SSA 1903(v)(3) and 42 CFR 440.255] the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (A) Placing the patient's health in serious jeopardy;
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part.

This definition must be met at the time medical service is provided, or it will not be considered to be an emergency medical condition. Not all services that are medically necessary meet the federal definition of treatment of an emergency medical condition.

PHYSICIAN'S CERTIFICATION:

In signing below, I certify that the care and services provided to the above named individual on the date(s) specified were for the purpose of treating an emergency medical condition as defined above.

The condition for which treatment was provided to the above named individual on the date(s) specified (please check one box):

- Meets the definition of an emergency medical condition described above.
- Does not meet the definition of an emergency medical condition described above.

Signature of Attending Physician _____ License # _____

Print Full Name _____

Provider/Facility Name _____ MMIS ID # or NPI _____ Date ____/____/____
MM DD YY

Address _____ City _____ State _____ ZIP _____
STREET

Attention LDSS Worker Please be sure that applicant/recipient signs the authorization on the reverse side of this form (in the language of his/her choice).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that the Local Department of Social Services must obtain information regarding emergency medical treatment rendered to me in order to determine my eligibility for Medical Assistance. I give permission to the local Department of Social Services to request such information and to the physician or facility to provide such information as requested by the local Department of Social Services for this purpose.

Signature of
Applicant/
Recipient/
Authorized
Representative _____

Date / /
MM DD YY

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA (Spanish)

Tengo conocimiento de que el Departamento de Servicios Sociales Local (Local Department of Social Services) debe obtener información con respecto a los tratamientos médicos de emergencia que recibí para determinar mi elegibilidad para asistencia médica. Doy mi autorización al Departamento de Servicios Médicos local para solicitar dicha información y al médico o institución para proporcionar dicha información según lo solicitado por el Departamento de Servicios Sociales a este fin.

Firma del
solicitante/
beneficiario/
Representante
autorizado _____

Fecha / /
MM DD YY

INSTRUCTIONS TO PROVIDERS FOR COMPLETING DOH-4471

Please print clearly.

PAGE 1:

- Please read the definition of an emergency medical condition on page one of the DOH-4471 form. Fill in the spaces for the patient's name, Client Identification Number (CIN), date of birth, address, city, state and zip code.
- The treating physician must fill in the diagnosis, describe the treatment provided and indicate the date(s) of treatment and/or hospital stay.
 - Only the treating physician may sign the physician's certification (no stamps please).
- Medicaid coverage may only be provided for the treatment of an emergency condition for a limited period of time and must be at least one day prior to the completion of this form.
 - The DOH-4471 form can accommodate up to four coverage periods (From-To Dates of Treatment/Hospital Stay).
 - The date of Treatment/Hospital Stay entered on the form begins with the first day of the emergency (i.e., From Date).
 - The maximum period of time that can be entered on a single DOH-4471 form is 90 days. This can be a combination of retroactive, current and prospective coverage.
 - Prospective coverage cannot exceed 60 days.
 - A new DOH-4471 form must be submitted for subsequent or continuing treatment for an emergency medical condition.
- Medicaid payment for emergency services is limited to the day the treatment was initiated through the following period of time in which the need for the emergency services exists.
 - In all cases, the treating physician must decide whether the medical treatment is for an emergency medical condition as described on this form and check the appropriate box indicating whether the treatment provided meets or does not meet this definition.
 - The treating physician must sign, date and print his/her full name and license number in the spaces provided at the bottom of the first page. Additionally, the name of the provider/facility, provider facility MMIS ID Number or NPI, and the complete address must be entered.

PAGE 2:

- **Please be sure the applicant/recipient signs the "Authorization to Release Medical Information" on the top of this page (in the language of his/her choice).**
- **This form must be sent to the local department of social services.**
- **Please keep a copy of this form for your records.**