NEW YORK STATE
DEPARTMENT OF HEALTH

AIDS INSTITUTE

UNINSURED CARE PROGRAMS

Pre-Exposure Prophylaxis Assistance Program

(PrEP-AP)

Practitioner

Specialty Provider Manual

1-800-832-5305

EMPIRE STATION
P.O. BOX 2052
ALBANY, NY
12220-0052

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE DEPARTMENT OF HEALTH/AIDS INSTITUTE

UNINSURED CARE PROGRAMS

Provider Manual to support the use of HIV Pre-exposure Prophylaxis (PrEP) through participation in the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

BACKGROUND

Pre-Exposure Prophylaxis (PrEP) is an HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected. Based on studies showing significant reduction in HIV acquisition among HIV-negative persons who use PrEP and receive a package of prevention, care and support services, the U.S. FDA approved combination anti-retroviral therapy (ART) for use as PrEP among sexually active adults at risk for HIV infection. A detailed description of the guidelines for the use of Pre-Exposure Prophylaxis (PrEP) to prevent HIV transmission can be found at: **http://www.hivguidelines.org**

POPULATION TO BE SERVED

PrEP-AP serves HIV-negative persons who are residents of New York State who are uninsured or underinsured.

CLIENT ELIGIBILITY

1) Residency - New York State

2) Medical - HIV-negative

3) Financial - Financial eligibility is based on 435% of the Federal Poverty Level (FPL). FPL varies based on household size and is updated annually. Households cannot have liquid assets greater than $25,000. Liquid assets are cash, savings, stocks, bonds, etc. Liquid assets do not include car, home or federally recognized retirement accounts

CLIENT ENROLLMENT PROCESS

Applicants apply to the Program using the HIV Uninsured Care Programs Application (DOH-2794), http://www.health.ny.gov/forms/doh-2794.pdf, providing proof of residency and income. A Medical Application completed by a practitioner is required to verify that the applicant is HIV-negative. Once eligible, a PrEP-AP Identification Card is sent to the applicant which can be used to receive covered services from enrolled providers.

GENERAL PROGRAM REQUIREMENTS

Qualified physician practitioners must be board certified or eligible for board certification and have hospital admitting privileges. All practitioners must be enrolled and active with New York State Medicaid.

REIMBURSABLE SERVICES UNDER PrEP-AP

The services reimbursable under PrEP-AP include the following medical services, provided on an out-patient ambulatory basis. PrEP-AP uses established fee for service Medicaid rate schedules and coding for payment of covered services. PrEP medication will be provided to uninsured individuals through the manufacturer patient assistance program (PAP). Providers

are responsible for assisting patients with the PAP application to receive Truvada as indicated for PrEP. The HUCP will staff a PrEP hotline to assist participants with the PAP process if problems or barriers are encountered and to refer participants to more comprehensive health care coverage when appropriate, no co-payment can be charged to participants. Reimbursement for office based visits under PrEP-AP are limited to;

1. **Initial Pre-Prescription Education and Evaluation** – Must include the following elements; evaluation and education for the patient regarding the risks, benefits, and options of PrEP. This education includes:

- How PrEP works as part of a comprehensive prevention plan;
- The limitations of PrEP;
- PrEP use, including dosing and adherence;
- Information regarding prevention of the transmission of HCV infection;
- Common side effects;
- The long-term safety of PrEP;
- Baseline tests and the schedule for monitoring;
- The criteria for discontinuing PrEP;
- The possible symptoms of seroconversion;
- For women, the potential benefits/risks if pregnancy occurs during use of PrEP;
- Perform laboratory tests (reporting of the test results to the patient):
    - Baseline HIV Test
        - Third-generation and fourth-generation HIV test
        - Nucleic acid amplification test (NAAT, viral load) for HIV for:
            - Patient with symptoms of acute infection
            - Patients whose antibody test is negative but who have reported unprotected sex with an HIV-infected partner in the last month
    - Basic Metabolic Panel
    - Urinalysis
    - Serology for Viral Hepatitis A, B, C
    - Screening for Sexually Transmitted Infections (NAAT for gonococcal and chlamydia infection-3 site screening (genital, rectal, pharyngeal)
    - Pregnancy Test

2. Prescribing and Monitoring PrEP

- Lab report and Prescription visit:
    - Write a 30 day prescription of Truvada (TDF/FTC), one tablet daily to begin when patient has a confirmed negative HIV test result
- 30-day visit:
    - Assess side effects
    - Serum creatinine and calculated creatinine clearance for patients with borderline renal function or at increased risk for kidney disease (>65 years of age, black race, hypertension, or diabetes)
    - Discuss risk reduction and provide condoms
    - Provide a 90 day prescription
- 3-month visit:
    - HIV test
    - Ask about STI symptoms
    - Discuss risk reduction and provide condoms

- Serum creatinine and calculated creatinine clearance
- Pregnancy test

- 6-month visit:
  - HIV test
  - Obtain STI screening tests
  - Pregnancy test
  - Discuss risk reduction and provide condoms
- 9-month visit:
  - HIV test
  - Ask about STI symptoms
  - Discuss risk reduction and provide condoms
  - Serum creatinine and calculated creatinine clearance
  - Pregnancy test
- 12-month visit:
  - HIV test
  - Obtain STI screening tests
  - HCV serology for MSM, IDUs and those with multiple sexual partners
  - Pregnancy test
  - Urinalysis
  - Discuss risk reduction and provide condoms

3. Discontinuation of PrEP Regimen

PrEP should be discontinued and the participant terminated from PrEP-AP if the patient:

- Receives a positive HIV test result
- Develops renal disease
- Is non-adherent to medication or appointments after attempts to improve adherence
- Is using medication for purposes other than intended
- Reduced risk behaviors to the extent that PrEP is no longer needed
- Requests discontinuation with referral to risk reduction support services and documentation of referral

Note: For women who become pregnant while using PrEP, continuation of PrEP during pregnancy is an individualized decision based on whether there are ongoing risks for HIV during pregnancy.

LAB/ANCILLARY SERVICES

Lab or ancillary services are reimbursable if;

They are performed by an ADAP Plus/PrEP-AP enrolled lab or ancillary vendor and are covered under the program.

Lab vendors are eligible to enroll in the program if they are actively enrolled in the New York State Medicaid Program and are certified by the New York State Department of Health.

If you are currently using a lab and they are not ADAP Plus/PrEP-AP enrolled, please refer the laboratory to provider liaison staff at 1-800-542-2437 for enrollment information.

Selected ancillary and laboratory services ordered by a practitioner are reimbursable to enrolled laboratory providers. Lab services can be performed and billed by the

practitioner, if the practitioner is considered a Certified Lab Vendor as defined by the New York State Department of Health.

HIV CLINICAL TRAINING

A detailed description of the guidelines for a the use of Pre-Exposure Prophylaxis (PrEP) to prevent HIV transmission can be found at: **http://www.hivguidelines.org**

CONFIDENTIALITY OF PRACTITIONER PARTICIPANTS

The names of practitioners who enroll in the PrEP-AP Program will not be disclosed to any agency or individual outside of the AIDS Institute or the NYS Department of Health without prior written approval of the participating practitioner except as may be otherwise required by Law. Enrolled practitioners are under *no* obligation to accept additional patients because of their participation in this program. *If requested* the Uninsured Care Programs will provide the practitioner's name and phone number to enrolled participants through its hot-line and on-line at the New York State Department of Health website.

BILLING PROCEDURES

This section contains the information needed by the provider to properly complete the claim form.

PROGRAM IDENTIFICATION CARDS

There is one Program Identification Card. Presentation of a Program Identification Card alone is not sufficient proof that a PrEP-AP participant is eligible for services. The Program Card must be used in conjunction with the electronic verification process (Dial 1-800-832-5305 to begin the payment authorization process) or through program staff during regular business hours. You must verify the eligibility of each participant each time services are requested or you risk the possibility of nonpayment for services which you provide.

THIRD PARTY HEALTH RESOURCES

If a PrEP-AP participant has other health care coverage, he/she is required to inform the Program of that coverage and assign all benefits associated with the use of that coverage to the Program. To mitigate participant out of pocket expenses the Program pays the fee for service Medicaid rate for covered services provided to eligible individuals. The program then bills the individuals other coverage. Acceptance of payment from PrEP-AP for covered services constitutes payment in full. Participants cannot be billed for services covered by the Program. **Do not bill third party payers or other insurance coverage for covered services.**

BILLING INSTRUCTIONS

This section of the Manual covers the preparation and submission of claim forms. This section relates to claims submitted manually rather than through electronic format. It is important that the provider use the outlined procedures. Claim forms which do not conform to the PrEP-AP requirements will not be processed or may result in a significant delay or denial of reimbursement.

Claim forms should be typed or printed legibly in order to reduce delays in processing. Claim forms may be submitted in quantity and enclosed in a single envelope which has been addressed to:

UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

Be sure to send the original claim (claims must be submitted within 90 days of the date of service) and retain a copy for your files. Information and instructions for the submission of electronic claims is included in the Primary Care electronic claim submission manual.

1.) PROVIDER ID NUMBER

Enter the 8-digit Medicaid Management Information System Identification Number, assigned to the provider at the time of enrollment in Medicaid. PrEP-AP will use this number as the identifying number for participation in the program. If this number is incorrect or the provider has been terminated from Medicaid no payments will be made.

Your MMIS/Medicaid Number must be used when ordering lab or ancillary services at an ADAP Plus participating vendor. Please call the PrEP-AP Hot-line, 1-800-542-2437 for a list of enrolled Laboratory Vendors

2.) PROVIDER BILLING TYPE

Use this space to indicate that you are billing as a private practitioner.

3.) LOCATOR CODE

This code indicates the location you have on file with the PrEP-AP Program. Enter the appropriate locator code that was assigned to the provider at the time of enrollment in Medicaid for the address where the service was performed.

NOTE: **The provider is reminded to register with the Department of Health, PrEP-AP each service location or change of service location to assure appropriate reimbursement. PrEP-AP cannot make payments for services provided at locator codes that are not valid in the Medicaid and PrEP-AP systems.**

4.) CATEGORY OF SERVICE

Use 0400 in all cases.

5.) BILLING DATE

Indicate in 2-digit numbers the month, day and year on which the claim form is submitted.

Examples: August 7, 2015 = 08/07/15

SPECIAL NOTE: **Because we are a grant funded Program all claims must be submitted within 90 days of the Date of Service unless the circumstances for the delay can be documented and sufficient funds are available to pay the claim.**

The following are the only circumstances under which a claim may be submitted after 90 days:

VALID EXPLANATION - acceptable reasons for late submissions are:

- Delay in PrEP-AP Client Eligibility Determination - must be submitted within thirty days from the time of application.
- Original claim rejected or denied due to a reason unrelated to the 90 day regulation - must be resubmitted within sixty days of the date of claim denial notification.

NOTE: **The 90 day submission period refers to calendar days.**

Single Submission - Attach a cover letter of one or more pages to the invoice indicate one of the acceptable reasons for late submission as shown above.

Batch Submission - Submit the claims with a cover letter of one or more pages detailing one of the acceptable reasons for the late submission as shown above.

If the provider's reason for submitting claims after 90 days does not fall within the "acceptable reasons" listed above, he/she may forward an appeal in writing to:

UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052

6.) INTERNAL ACCOUNT NUMBER (OPTIONAL)

The Provider for record-keeping purposes may wish to identify a Participant by using an office account number (up to 10 characters). If this office account number is indicated on the claim form, PrEP-AP will print the number on the Remittance Statement for the convenience of the Provider. This is useful in locating accounts when there is a question regarding Participant Identification.

NOTE: For confidentiality purposes the only client identifiers to be used on the remittance statement are; Internal Account Number and the PrEP-AP Participant ID.

7.) PLACE OF SERVICE

Enter the code for practitioners office (1)

8.) PROVIDER NAME and ADDRESS

The Provider's Name and Correspondence Address

NOTE: It is the responsibility of the provider to notify the New York State Department of Health PrEP-AP of any change of address or other pertinent information within 15 days of the change.

9.) MD NAME

Enter the last and first name of the individual practitioner who rendered the service.

10.) LICENSE NUMBER

Enter the license number assigned to the individual practitioner who rendered the service(s) to the participant.

11.) TYPE (LICENSE)

Enter the appropriate 2-digit code which indicates the profession or specialty of the practitioner who provided the service.

12.) PARTICIPANT ID NUMBER

Enter the participant's 11-character alpha/numeric PrEP-AP ID Number in the space titled "Participant ID Number."

NOTE: **The first 10 characters of the ID number are numeric; the next one is alpha (i.e. 555001000-O-A).**

13.) DATE OF BIRTH:

Indicate in 2 digit numbers the month, day and year of birth.

Example: Dee Jones was born on September 12, 1960.
Enter 09/12/60 in this field.

14.) SEX

Place an X to the right of "M" for Male, "F" for Female and "T" for Transgender.

15). PARTICIPANT NAME

Enter the last name followed by the first name of the participant as it appears on the PrEP-AP ID Card:

Example: Jones, Dee

16.) PATIENT STATUS CODE

This code indicates a specific condition or status of the participant as of the last Date of Service on the claim form. Enter in this field one of the numbers below:

Continuing Care 0
Deceased 1
Admitted to Hospital 2
Admitted to Skilled Nursing Facility (SNF) 3
Admitted to Intermediate Care Facility (ICF or HRF) 4
Admitted to Domiciliary Care Facility (DCF) 5
Plan of Care Completed 6
Care terminated due to eligibility or other reason 7
Participant Medicaid Eligible 8
Transferred to Home Health Care Agency 9
Admitted to Long Term Home Health Care 10

17.) DIAGNOSIS CODE PRIMARY

Enter in this field appropriate ICD-9-CM code which describes the primary condition or symptom of the participant in evidence on the service date for which the claim is being submitted.

18.) SECONDARY

Enter the appropriate ICD-9-CM code which represents the most important secondary condition or symptom affecting treatment. If not appropriate, leave this field blank.

19.) RECORD NUMBER

This field will be assigned by PrEP-AP and will be used as the reference number for any claim inquiries and remittance advice.

20.) DATE OF SERVICE

Indicate in 2-digit numbers, the month, day and year on which a service was rendered. Be sure to enter a date of service for each procedure description.

Example: July 15, 2001 = 07/15/01

21.) RATE CODE

Enter the appropriate CPT Procedure as described in this manual.

22.) PROCEDURE DESCRIPTION

Describe each procedure rendered to the participant in this field. Descriptions will assist staff in identifying services rendered when Rate Codes or Procedure Codes are recorded incorrectly.

23.) TOTALS

Total each column where entries appear.

24.) SIGNATURE and DATE

The provider or an authorized representative must sign each claim form.

Enter the date on which the provider or an authorized representative signed the claim form.

REMITTANCE STATEMENT

The purpose of this section is to familiarize the provider with the design and contents of the Remittance Statement. This document plays an important role in the communication between the provider and the Program. Aside from showing a record of transactions, the Remittance Statement assists providers in resolving and correcting possible errors on denied claims.

REJECTED CLAIMS – CLAIMS THAT CANNOT BE ENTERED INTO OUR SYSTEM ARE RETURNED TO THE PROVIDER IMMEDIATELY. SINCE THEY ARE NOT ENTERED INTO THE COMPUTER SYSTEM, THEY ARE NOT SHOWN ON THE REMITTANCE STATEMENT.

PrEP-AP produces a Remittance Statement for each payment cycle (approximately bi-weekly) which contains all claims that have been entered in the processing system. The Remittance Statement indicates the status of the claims (paid/denied).

DENIED CLAIMS

A claim will be denied if service rendered is not covered by PrEP-AP, if it is a duplicate of a prior claim, if the participant is not eligible on the date of service, or if data is invalid or logically inconsistent.

The provider should review his/her copy of the denied claim, which is indicated on the Remittance Statement and, where appropriate, completely resubmit the claim with justification of reasons for approval. Providers should not resubmit claims which have been denied due to practices which contradict either good medical practice or program policy. The Program will accept an annotated photocopy or duplicate copy of an original claim for the purpose of resubmission.

EXPLANATION OF COLUMNS ON REMITTANCE STATEMENT

(1-2) PrEP-AP CLAIM NUMBER/LINE
This column indicates the Record Number which is assigned by the program.

(3) INTERNAL ACCOUNT NUMBER
The Office Account Number is optional for the provider and will only appear if it has been indicated on the claim form.

(4) CLIENT ID NUMBER
This column lists the Participant/Client ID Number.

(5) DATE OF SERVICE
This column lists the Dates of Service which have been entered on the claim form.

(6) PROCEDURE/RATE CODE
This column lists the Rate or Procedure Codes as entered on the claim form.

(7) DESCRIPTION OF SERVICE
This column indicates the descriptive reference associated with the procedure code.

(8) BILLED
This column indicates the amount billed.

(9) PAID
This column indicates the amount of the PrEP-AP payment.

(10-11) STATUS/COMMENTS
These columns indicate the status of each claim line along with any appropriate comments, denial codes.

INFORMATION

The Remittance Statement, as described above, will be the key control document which informs the provider of the current status of submitted claims. Should further information be required on any detail on the Remittance Statement, Providers should contact PrEP-AP at 1-800-832-5305.